PPO Design

Benefit Book

Yuma County Employee Benefit Trust

Group # 29159

Effective January 1, 2014

azblue.com

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Yuma County Employee Benefit Trust
PPO Benefit Plan

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") to provide its employees with health care coverage. The Plan is established by your employer and is maintained pursuant to a written document called the Yuma County Employee Benefit Trust (YCEBT), Plan Document (the "YCEBT Plan Document"). The PPO Benefit Plan document is part of the YCEBT Plan Document.

YCEBT has contracted with Blue Cross Blue Shield of Arizona ("BCBSAZ") to provide certain administrative claims processing, access to a PPO network, and utilization management services for this PPO benefit plan. Benefits under the Plan are paid from the general assets of YCEBT.

BCBSAZ, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BCBSAZ is an independent contractor and shall not for any purpose be deemed an agent of your employer or the employer's Plan Administrator*, nor shall BCBSAZ and your employer be deemed partners, joint venturers or governed by any legal relationship other than that of independent contractor. In this book, BCBSAZ refers to the administrative services agreement with YCEBT as a "group master contract."

This benefit book describes the benefits for employees and their dependents that are eligible for and have elected coverage, under the PPO benefit plan.

This PPO benefit plan gives you access to a network of providers that have agreed to negotiated discounts with BCBSAZ or a local Blue Cross and/or Blue Shield plan if covered services are rendered outside of Arizona.

Please note: Not all services are covered. As this is a self-funded employer health care plan, benefits provided in this PPO plan may not include all benefits required for those health care plans which are not self-funded. Read this benefit book carefully to understand the benefits and limitations of the PPO benefit plan.

Plan Sponsor and Plan Administrator refer to YCEBT.

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact BCBSAZ at one of the departments listed below or call the phone number on the back of your ID card.

BlueNet

BCBSAZ also makes information available at www.azblue.com and you may wish to look there before calling. BlueNet is the member area on www.azblue.com that allows you to manage your health insurance plan from anywhere you have Internet access. Go to www.azblue.com/member for more information and to register for a BlueNet account. After you register for BlueNet, you can*:

View claims and benefits information
Track deductible, if applicable to your plan
Update account information
Verify enrollment status
Order ID cards
Search for providers
Compare hospitals
Review Medical and Dental Coverage Guidelines
Access HealthyBlue® - tools for a healthier life

*Access to BlueNet links and services will vary based on benefit plan type.

BCBSAZ Customer and Membership Services

Phone service hours are Monday through Friday, 8:00 a.m. to 4:30 p.m. MST (except holidays).

	Customer Service: • **All General Questions & Information** • **Claim Issues**	**Membership Services:** • **Enrollment Questions** • **Dependent Changes** • **Premium Billing & Payment**	**Hearing Impaired (TDD) (Claim Information)**	**Spanish-Language Phone Service (en Español – preguntas sobre su solicitud, beneficios, reclamos, o pagos)**
Maricopa County:	(877) 475-8445	(602) 864-4456	(602) 864-4823	(602) 864-4884
Pima County:	(877) 475-8445			
Statewide:	(877) 475-8445	(800) 232-2345, ext. 4456	(800) 232-2345, ext. 4823	(800) 232-2345, ext. 4884
Fax:		(602) 864-4041		
Mailing Address:	All Correspondence Except as Noted Below: Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466	Attn: Membership Services, Mail Stop: A102, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466		

Customer Walk-In Office Locations

Phoenix (main office):	2444 W. Las Palmaritas Drive, 85021-4883 (2 blocks north of Northern Avenue between the Black Canyon Freeway (I-17) and 23rd Avenue)
Tucson:	5285 E. Williams Circle, Suite 1000, 85711-7411 (East on Broadway Road, right on S. Williams Circle, right on E. Williams Circle)
Flagstaff:	1500 E. Cedar Avenue, Suite 56, 86004-1643 (Intersection of Cedar Avenue and West Street)
Chandler:	2121 W. Chandler Blvd., Suite 115, 85224-6576 (East of the 101 Freeway, West of Dobson Road)

Provider Locator & Benefit Vendor Information

BlueCard® Program (getting care outside of Arizona):	Blue Cross Blue Shield Association: (800) 810-2583 or website at www.bcbs.com
Chiropractic Benefits Administrator (CBA):	(800) 678-9133
Provider Network Status:	Check the online provider directory at www.azblue.com or call BCBSAZ Customer Service at the numbers listed above

Claim Submissions

Mail New Claims to:	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix, AZ 85062-2924
Claims for Transplant Travel and Lodging:	Attention: Transplant Travel Claim Processor, Mail Stop: A225, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
Claims for Services Received on a Cruise Ship:	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
Claims for Chiropractic Services:	Claims Administration, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001

Accessing Care

Clinical Trials (for information on services directly associated with a clinical trial or to obtain a copy of the requirements for clinical trials):	Maricopa County: (602) 864-5841 Statewide: (800) 232-2345, ext. 5841
Care Management and Disease Management Support Line (information on care management services, how to contact a care manager or how to make a referral and information on health management programs that support members with complex, catastrophic and/or chronic conditions):	(877) My-HBlue or (877) 694-2583
Continuity of Care Requests:	(877) My-HBlue or (877) 694-2583
Precertification (your doctor must contact BCBSAZ):	Maricopa County: (602) 864-4320 Statewide: (800) 232-2345, ext. 4320

Disputes

	Medical Appeals and Grievances (except as noted below)	**Precertification Denial Appeals** (you or your doctor may contact BCBSAZ)
Maricopa County:	(602) 544-4938	(602) 544-4938
Statewide:	(866) 595-5998	(866) 595-5998
Fax:	(602) 544-5601	(602) 544-5601
Mailing Address:	Attn: Medical Appeals and Grievances, Mail Stop: A116, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466	
For disputes over chiropractic care:	Appeals Coordinator, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001; Telephone (800) 678-9133; Fax (619) 209-6237	

Document and Form Requests

Medical Coverage Guidelines (request a copy of the Medical Coverage Guidelines):	Maricopa County: (602) 864-4614 Statewide: (800) 232-2345, ext. 4614 BlueNet members' area of www.azblue.com under Claims & Benefits/Health Benefits/Medical Coverage Guidelines
Requests for Transplant Travel and Lodging Claim Forms:	Maricopa County: (602) 864-4051 Statewide: (800) 232-2345, ext. 4051
Supply Line (provider directories, claim forms, Summaries of Benefits and Coverage, BCBSAZ Appeal and Grievance Guidelines, ID cards):	Maricopa County: (602) 995-6960 Statewide: (800) 232-2345, ext. 6960

Social Media

Like us on Facebook: www.facebook.com/bcbsaz
Follow us on Twitter: www.twitter.com/bcbsaz
Email complaints and concerns to socialcares@azblue.com
iPhone and Android phone users can download our mobile application via Google Play or App Store

DEFINITIONS

"Allowed amount" means the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost-share payment.

BCBSAZ calculates deductible and coinsurance based on the allowed amount, less any access fees or precertification charges. BCBSAZ uses the allowed amount to accumulate toward any out-of-pocket maximum that applies to the member's benefit plan. The allowed amount does not include any balance bills from noncontracted providers. The allowed amount is neither tied to, nor necessarily reflective of, the amounts providers in any given area usually charge for their services.

If the allowed amount is based on a Fee Schedule, a change to the Fee Schedule may result in higher member cost-share.

The table below shows how BCBSAZ determines the allowed amount.

Type of Provider	Type of Claim	Basis for Allowed Amount
Providers contracted with BCBSAZ	Emergency and non-emergency	Lesser of the provider's billed charges or the applicable BCBSAZ fee schedule, with adjustments for any negotiated contractual arrangements and certain claim editing procedures
Providers contracted with a vendor	Emergency and non-emergency	Generally, the lesser of the provider's billed charges or the vendor's fee schedule, with adjustments for any negotiated contractual arrangements
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue")	Emergency and non-emergency	Lesser of the provider's billed charges or the price the Host Blue plan has negotiated with the provider
Noncontracted providers (in Arizona and out-of-state)	Non-emergency claims and emergency ground ambulance claims	Lesser of the provider's billed charges or the applicable BCBSAZ fee schedule, with adjustments for certain claim editing procedures. For emergency ground ambulance claims, the allowed amount is generally based upon the ambulance provider's billed charges.
Noncontracted providers (in Arizona and out-of-state)	Emergency	Billed charges

"BCBSAZ" or "We" means Blue Cross Blue Shield of Arizona, when acting as the issuer of insurance coverage or as the administrator of a group benefit plan. Within this benefit book, "BCBSAZ" or "We" may also include contracted vendors, when a contracted vendor is performing functions on behalf of BCBSAZ.

Blue Cross® Blue Shield® of Arizona is an independent licensee of the Blue Cross and Blue Shield Association.

BCBSAZ is a nonprofit corporation organized under the laws of the State of Arizona as a hospital, medical, dental and optometric services corporation and is authorized to operate a health care services organization as a line of business.

"Bariatric surgery" means a surgical procedure to promote weight loss for the treatment of morbid obesity. Bariatric surgery also includes any revisions to a bariatric surgical procedure.

"Benefit book" means this document, which may also be referred to as benefit booklet or benefit plan booklet.

"Benefit plan" or "plan" means the document describing the benefits and terms of coverage that the sponsor of a group health plan provides to its group members and their Dependents. Your BCBSAZ plan includes this book and any SBC, your application for coverage, your ID card, any plan that is issued to replace this plan and any rider, amendment or modification to this plan, including but not limited to, any changes in deductible, coinsurance or copay amounts. **Changing deductible options within a product does not constitute a new plan.**

"Billed charges" means:

- For a provider that has a participation agreement governing the amount of reimbursement, the amount the provider routinely charges for a service;

- For a provider that has no participation agreement governing the amount of reimbursement, the lowest amount that the provider is willing to accept as payment for a service.

"Chiropractic Benefits Administrator (CBA)" means American Specialty Health Networks, Inc., the independent company that administers chiropractic benefits for BCBSAZ. The CBA develops and manages the BCBSAZ network of chiropractic providers, processes chiropractic claims, determines medical necessity and handles utilization management, grievances and appeals related to chiropractic services.

"Contractholder" means the person to whom the benefit plan is issued. Any other person approved for coverage with the Contractholder under this plan is a Dependent. Under group coverage, the Contractholder is the member who is eligible for coverage because of his or her affiliation with a Group.

"Cosmetic" means surgery, procedures or treatment and other services performed primarily to enhance or improve appearance, including but not limited to, those surgeries, procedures, treatments and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological or mental condition or function.

"Cost-share" means the member's financial obligation for a covered service. Depending on the plan type, cost-share may include one or more of the following: deductible, copay, access fee, coinsurance, precertification charges, and balance bills.

"Custodial care" means health services and other related services that meet any one or more of the following criteria:

1. Are for comfort or convenience;
2. Do not seek to cure;
3. Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition or other self-care; **or**
4. Are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as an L.P.N., R.N. or licensed therapist.

"Diagnosis Related Grouping" or "DRG" means a method for reimbursing hospitals for inpatient services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that failing to get immediate medical attention would result in serious jeopardy to the patient's life, health or ability to completely recover, serious impairment to a bodily function or part, or permanent disability.

"FDA" means the federal Food and Drug Administration.

"FDA-approved" means that a medication or device has been approved by the FDA.

"Fee Schedules" mean proprietary schedules of provider fees compiled by BCBSAZ or BCBSAZ's contracted vendors. BCBSAZ or BCBSAZ's contracted vendors develop proprietary schedules of fees based on annual reviews of information from numerous sources, including, but not limited to: Medicare fee schedules from the Centers for Medicare and Medicaid Services (CMS), BCBSAZ's or the contracted vendor's historical claims experience, pricing information that may be available to BCBSAZ or the vendor, information and comments from providers and negotiated contractual arrangements with providers. **BCBSAZ and/or BCBSAZ's contracted vendors may change their Fee Schedules at any time without prior notice to members. If the allowed amount is based on a Fee Schedule, a change to the Fee Schedule may result in higher member cost-share.**

"Group" means the employer, trust or other entity that sponsors the group benefit plan on behalf of its employees or participants.

"Group Master Contract" (sometimes referred to as "Agreement") means the legal agreement between the Group and BCBSAZ.

“Inpatient residential care” means medical or mental-behavioral care provided in a 24-hour facility licensed by the state in which it is located, and not licensed as a hospital, that offers integrated therapeutic services, educational services and activities of daily living. These services are part of a well-defined, individually tailored, medical or mental-behavioral treatment plan that is clinically appropriate based upon the individual’s medical or mental-behavioral needs and is performed in a clinically appropriate facility.

“Medical Coverage Guidelines” means BCBSAZ medical, pharmaceutical, dental and administrative criteria that are developed from review of published, peer-reviewed medical, pharmaceutical and dental literature and other relevant information and used to help BCBSAZ determine whether a service, procedure, medical device or drug is eligible for benefits under a member's benefit plan. The Medical Coverage Guidelines also include prescription medication limitations. BCBSAZ periodically reviews and amends the Medical Coverage Guidelines in response to changes and advancements in medical knowledge and scientific study. Benefit determinations are based on the Medical Coverage Guidelines in effect at the time of service. You or your provider can review a specific guideline by going to the "Claims & Benefits" section on www.azblue.com and choosing "Health Benefits and Medical Coverage Guidelines." Specific Guidelines are also available by calling the number for requesting Medical Coverage Guidelines listed in the front of this book.

BCBSAZ contracted vendor(s) may establish medical coverage guidelines for services the vendor provides or administers pursuant to the vendor’s contract with BCBSAZ.

"Member" or "You" means an individual, employee, participant or Dependent covered under a benefit plan.

“Per diem” means a method of reimbursement based on a negotiated rate per day for payment of covered services provided to a patient in a facility.

“Physician,” for purposes of classifying benefits and member cost-shares in this benefit plan, means a properly licensed M.D., D.O., D.P.M., or D.C.

“Primary Care Provider (PCP)” means a health care professional who is contracted with BCBSAZ as a PCP and generally specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, pediatrics or any other classification of provider approved as a PCP by BCBSAZ. Your benefit plan does not require you to have a PCP or to have a PCP authorize specialist referrals.

“Provider” means any properly licensed, certified or registered person or facility furnishing medical care to you, such as a doctor, hospital, laboratory or other health professional.

“Rehabilitation Services” are services that help a person restore skills and functioning for daily living lost due to injury or illness.

“Respite Care” is the provision of short-term, temporary relief of the daily routine and stress to provide those who are caring for family members a personal break from their role as caregiver.

"Service" means a generic term referencing some type of health care treatment, test, procedure, supply, medication, technology, device or equipment.

“Specialist” means either a physician or other health care professional who practices in a specific area other than those practiced by primary care providers, or a properly licensed, certified or registered individual health care provider whose practice is limited to rendering mental health services. For purposes of cost-share, this definition of “specialist” does not apply to dentists. BCBSAZ does not require you to obtain an authorization or referral to see a specialist.

“Summary of Benefits and Coverage” (SBC) means a federally required document in a specified template with information on applicable copays, access fees, coinsurance percentages, deductible amounts, other cost-sharing amounts, benefits, exclusions, limitations; and other important information. BCBSAZ generally sends SBCs with member ID cards. Please keep your current SBC with your benefit book.

UNDERSTANDING THE BASICS

Your Responsibilities

Before you get services:

- Read your benefit materials.
- Know your coverage.
- Know the limits and exclusions on coverage.
- Know how much cost-share you will have to pay.
- Check your provider's network status and know whether your provider is a network provider with BCBSAZ.

After you get services:

- Read your explanations of benefits (EOBs) and monthly health statements.
- Tell BCBSAZ if you see any differences between the amounts on your claims documents and what you actually paid.

BCBSAZ ID Card

BCBSAZ will mail you an ID card with basic information about your coverage:

- Who is covered (Contractholder and Dependent names)
- Identification numbers
- Cost-share amounts
- Important phone numbers and addresses
- Bring your ID card with you each time you seek health care services.
- Have your ID card available for reference when you contact BCBSAZ for information.

Coverage Changes

Your benefits and coverage can change while this benefit plan is in effect. You will be notified of any changes as required by law. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your Group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available.

Covered Services

To be covered, a service must be all of the following:

- A benefit of this plan;
- Medically or dentally necessary as determined by BCBSAZ or BCBSAZ's contracted vendor(s);
- Not excluded;
- Not experimental or investigational as determined by BCBSAZ or BCBSAZ contracted vendor(s);
- Precertified where precertification is required;
- Provided while this benefit plan is in effect and while the person claiming benefits is eligible for benefits; **and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ or BCBSAZ's contracted vendor(s).

Experimental or Investigational Services

BCBSAZ, in its sole and absolute discretion, decides whether a service is experimental or investigational. A service is considered experimental or investigational unless it meets <u>all</u> of the following criteria:

- The service must have final approval from the appropriate governmental regulatory bodies if applicable;
- The scientific evidence must permit conclusions concerning the effect of the service on health outcomes;
- The service must improve the net health outcome;
- The service must be as beneficial as any established alternative; **and**
- The improvement resulting from the service must be attainable outside the investigational setting.

In addition to classifying a service as experimental or investigational using the above criteria, BCBSAZ or its contracted vendor may also classify the service as experimental or investigational if any one or more of the following apply:

- The service cannot be lawfully marketed or used without full (unrestricted) approval of appropriate governmental regulatory bodies and approval for marketing or use has not been given at the time the service is submitted for precertification or rendered;
- The provider rendering the service documents that the service is experimental or investigational; **or**
- Published reports and articles in authoritative (peer-reviewed) medical and scientific literature show that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, appropriate selection, efficacy or efficacy as compared with the standard treatment for the diagnosis.

Medically Necessary

BCBSAZ, or BCBSAZ's contracted vendor, in its sole and absolute discretion, decides whether a service is medically necessary based on the following definition:

A medically necessary service is a service that meets all of the following requirements:

- Is consistent with the diagnosis or treatment of a symptom, illness, disease or injury;
- Is not primarily for the convenience of a member or a provider;
- Is the most appropriate site, supply or service level that can safely be provided; **and**
- Meets BCBSAZ's medical necessity guidelines and criteria in effect when the service is precertified or rendered. If no such guidelines or criteria are available, BCBSAZ or its contracted vendor will base its decision on the judgment and expertise of a medical professional or medical consultant retained by BCBSAZ or the vendor.

Medical Necessity Guidelines and Criteria

BCBSAZ uses some of the sources and criteria listed below to make medical necessity decisions, but does not rely on each source for every decision. Information on how to obtain a copy of the Medical Coverage Guidelines is in the Customer Service section at the front of this book.

- Medical Coverage Guidelines (local medical policy)
- InterQual ® Clinical Decision Support Criteria
- Medical Policy Reference Manual (MPRM) of the Blue Cross Blue Shield Association
- Medicare Guidelines
- Technology Evaluation Center (TEC) of the Blue Cross Blue Shield Association

Decisions about medical necessity may differ from your provider's opinion. A provider may prescribe, order, recommend or approve a service that BCBSAZ decides is not medically necessary and therefore is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered. Also, not all medically necessary services are covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A service may be medically necessary and still excluded from coverage.

BCBSAZ contracts with vendors to administer some or all of the benefits covered under this plan. These contracted vendors make medical necessity determinations based on their own medical necessity criteria, which are also available to you on request.

PROVIDERS

Know your provider's network and eligibility status before you receive services.

Provider Directory

The BCBSAZ provider directory is available online at www.azblue.com. If you do not have Internet access, call BCBSAZ Customer Service to check a provider's eligibility and network status.

Provider Eligibility and Network Status

To be **eligible** for coverage, a service must be rendered by an eligible individual provider acting within his or her scope of practice, and, when applicable, performed at an eligible facility that is licensed or certified for the type of procedure and services rendered.

Eligible Providers

Not all medical professionals are eligible providers. Eligible providers include the properly licensed, certified or registered providers listed below, when acting within the scope of their practice and license. Scope of practice is determined by the regulatory oversight agency for each health profession. It means the procedures, actions, and processes that a licensed or certified medical professional is legally allowed to perform based on the individual's specific education and experience, and demonstrated competency. For example, neurosurgery would not be within the scope of practice for a dentist.

Benefits may also be available from other health care professionals whose services are mandated by Arizona state law or federal law or who are accepted as eligible by BCBSAZ. The following are examples of ineligible providers: acupuncturists and doctors of naturopathy and homeopathy. Other provider types may also be ineligible. The fact that a service is rendered by an eligible provider does not mean that the service will be covered. Not all eligible providers are contracted to participate in BCBSAZ networks.

ELIGIBLE PROVIDER LIST	
Professional	**Facility Ancillary**
• Board Certified Applied Behavioral Analyst (BCABA) • Certified Nurse First Assist (CRNFA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Doctor of chiropractic (D.C.) • Doctor of dental surgery (D.D.S.) • Doctor of medical dentistry (D.M.D.) • Doctor of medicine (M.D.) • Doctor of optometry (O.D.) • Doctor of osteopathy (D.O.) • Doctor of podiatry (D.P.M.) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner • Licensed professional counselor • Physician Assistant (PA) • Psychologist (Ph.D., Ed.D. and Psy.D.) • Perfusionist • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational or physical therapist • Surgical Assist (SA) • Surgical Technician (ST)	• Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long Term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Rehabilitation Treatment Centers (substance abuse centers) • Retail, mail order and specialty pharmacies • Skilled Nursing Facility • Specialty Laboratory • Sleep Lab • Urgent Care

Choosing a Provider

Your costs will be lower when you use an in-network provider. Before receiving scheduled services, verify the network status of all providers who will be involved in your care, such as assistant surgeons, anesthesiologists and radiologists, as well as the facility where the services will be performed.

Network Status

In-Network Providers (Contracted)

- In-network providers are the following: (1) health care providers licensed in the United States who have a contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for BCBSAZ members); and (2) out-of-state health care providers licensed in the United States who have a PPO contract with a Host Blue plan.

- In-network providers will file your claims with BCBSAZ or the Host Blue plan with which they are contracted. The provider's contract generally prohibits the provider from charging more than the allowed amount for covered services. However, when there is another source of payment, such as liability insurance, all providers may be entitled to collect their balance bill from the other source, or from proceeds received from the other source. The provider's contract does allow the provider to charge you up to the provider's billed charges for noncovered services. We recommend that you discuss costs with the provider before you obtain noncovered services. BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan directly reimburse in-network providers for your benefit plan's portion of the allowed amount for covered services. **You are responsible to pay your member cost-share directly to the provider.**

- Except for emergencies, in-network providers must render covered services in the United States for the services to be considered in-network and subject to in-network member cost-share. If an in-network provider renders covered services outside the United States, the services will be considered out-of-network and subject to out-of-network member cost-share, including balance bills (except for emergencies).

Out-of-Network Providers (Contracted and Noncontracted)

- Out-of-network providers are: (1) Providers who are contracted with a Host Blue plan as "Participating" only providers; (2) Eligible providers who have no contract with BCBSAZ or a Host Blue plan (Noncontracted providers), and (3) Providers who are contracted with the BlueCard Worldwide program.

- **Participating-Only Providers**

  Participating-only providers are contracted with a Host Blue plan as "Participating" and are not contracted as PPO or Preferred providers. Participating-only providers are out-of-network providers. Participating-only providers will submit your claims to the Host Blue plan with which they are contracted. If you receive covered services from a Participating-only provider, you will pay out-of-network deductible and coinsurance and access fees. However, you will not have to pay the balance bill because the provider is contracted.

- **Noncontracted Providers**

  Eligible providers who have no provider participation agreement with BCBSAZ or any Host Blue plan are noncontracted providers. Noncontracted providers are out-of-network providers.

  If you receive covered services from an eligible noncontracted provider, you will pay out-of-network deductible and coinsurance, access fees and the balance bill. Noncontracted providers may bill you up to their full billed charges. The difference between the noncontracted provider's billed charges and payment under this benefit plan may be substantial. Please check with the noncontracted provider regarding the amount of your financial responsibility before you receive services.

  BCBSAZ does not send claim payments to noncontracted providers. BCBSAZ will send payment to you for whatever benefits are covered under your benefit plan. You are responsible for paying the noncontracted provider. A noncontracted provider will not receive a copy of your explanation of benefits (EOB) and will not know the amount this benefit plan paid you for the claim.

- **Providers Contracted with the BlueCard Worldwide Program**

  Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. For covered services from these providers, you will pay out-of-network deductible and coinsurance and access fees (except for emergency services), plus the balance bill.

Eligible Provider Status and Payment – Summary Table Subject to all terms and conditions noted in this section.				
Provider Contract Status	**Network Status and Applicable Cost-Share**	**Provider Required to File Claim on Member's Behalf**	**Accept BCBSAZ Allowed Amount and Do Not Balance Bill**	**Payee for Reimbursement**
Providers contracted with BCBSAZ	In-network	Yes	Yes	BCBSAZ reimburses the **provider** the allowed amount, less any member cost-share
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue") as PPO providers	In-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share
Providers contracted with Host Blue as Participating only providers	Out-of-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share
Providers contracted with Blue Card World Wide Program	Out-of-network	Yes	No	Blue Card Worldwide reimburses the **provider** the allowed amount less any member cost-share
Noncontracted providers (in Arizona and out-of-state) (must be eligible providers)	Out-of-network	No (provider may elect to do so as courtesy to member)	No. May charge up to full billed charges. Difference between billed charges and BCBSAZ member reimbursement may be substantial.	BCBSAZ reimburses the **member** the allowed amount, less any member cost-share. Provider does not get copy of member's EOB or know reimbursement amount.

Sample Differences in Financial Responsibility Based on Provider Choice

The following **example** shows how out-of-pocket expenses can differ depending on the provider you choose. This example is provided for demonstration purposes only. Your savings may vary depending on your benefit plan and your chosen provider.

In this example, the member has already satisfied the calendar-year deductible and has a 20 percent coinsurance for an in-network provider and 40 percent coinsurance for an out-of-network provider.

Billed Charges	**Allowed Amount**	**Financial Responsibility**	**In-Network Providers 20% Coinsurance**	**Out-of-Network (Noncontracted) Providers 40% Coinsurance**
$1,000	$400	BCBSAZ pays:	$320	$240
		You pay:	$ 80 coinsurance amount	$160 coinsurance +600 balance bill $760

Locating an In-Network Provider

Check the BCBSAZ provider directory to locate an in-network provider who offers the services you are seeking and contact the provider for an appointment. If you cannot get an appointment with the in-network provider, you may either call BCBSAZ or ask an in-network provider with whom you have an existing treatment relationship for help in getting an appointment or locating another provider.

Precertifications for Out-of-Network Providers

BCBSAZ does not guarantee that every specialist or facility will be in our network. Not all providers will contract with health insurance plans. If you believe or have been told there is no in-network provider available to render covered services that you need, you may ask your treating provider to request precertification of in-network cost-share for services from an out-of-network provider. BCBSAZ will not issue this precertification if we find that an in-network provider is available to treat you. The section on precertification explains how to make this request.

Continuing Physician Care from an Out-of-Network Physician (M.D., D.O.)

You may be able to receive benefits at the in-network level for services from an out-of-network Arizona physician, under the circumstances described below. Continuity of care benefits are subject to all other applicable provisions of your benefit plan.

Continuity of care only applies to otherwise covered services rendered by doctors of medicine and osteopathy who are located in Arizona. Continuity of care is not available for facility services. If the hospital or other facility at which your physician practices is not an in-network facility, the out-of-network provisions of coverage will apply to covered facility services.

Information on requesting continuity of care is listed in the BCBSAZ Customer Service section at the front of this book.

<table>
<tr><th>New Members</th><th>Current Members</th></tr>
<tr><td>A new member may continue an active course of treatment with an out-of-network Arizona physician during the transitional period after the member's effective date if:

The member has:

1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of coverage; or

2. Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; and</td><td>A current member may continue an active course of treatment with an out-of-network Arizona physician if BCBSAZ terminates the physician from the network for reasons other than medical incompetence or unprofessional conduct if:

The member has:

1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of the physician's termination; or

2. Entered the third trimester of pregnancy on the effective date of the physician's termination, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; and</td></tr>
<tr><td colspan="2">The member's physician agrees in writing to do all of the following:

1. Accept the BCBSAZ allowed amount applicable to covered services as if provided by an in-network physician, subject to the cost-share requirements of this benefit plan;
2. Provide BCBSAZ with any necessary medical information related to your care; and
3. Comply with BCBSAZ's policies and procedures, as applicable, including precertification, network referral, claims processing, quality assurance and utilization review.</td></tr>
</table>

Out-of-Area Services

BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Plans referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Arizona, but inside the United States (not BlueCard Worldwide), the claims for those services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between BCBSAZ and other Blue Cross and/or Blue Shield Plans. National Account arrangements are contractual agreements between BCBSAZ and other Blue Cross and/or Blue Shield Plans regarding reimbursement for covered services provided to members of certain self-funded group health plans by providers contracted with the other Blue Cross and/or Blue Shield Plans.

Typically, when accessing care outside Arizona but inside the United States (not BlueCard Worldwide), you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Plan in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-contracted healthcare providers. BCBSAZ's payment practices in both instances are described in this benefit plan book.

BlueCard Program

Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for fulfilling BCBSAZ's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Arizona, but inside the United States (not BlueCard Worldwide), and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed charges for your covered services; **or**
- The negotiated price that the Host Blue makes available to BCBSAZ.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSAZ uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Precertification requirements and other benefit plan limitations apply to services received outside Arizona. You must make sure the provider obtains any required precertification. Otherwise, BCBSAZ may deny your benefits or require you to pay a precertification penalty.

For assistance in locating a local BCBS network provider in another state, call (800) 810-BLUE (2583) or check the "BlueCard Doctor & Hospital Finder" online at www.bcbs.com.

See the "Provider" section and the definition of "Allowed Amount" in this benefit book for information regarding payment for services provided by non-contracted providers outside Arizona.

BlueCard Outside the United States (BlueCard Worldwide)

Always go directly to the nearest hospital in the event of an emergency. Emergency services are covered outside the United States. In-network member cost-sharing will apply to covered Emergency Services. See the Emergency Services section of this benefit book.

The BlueCard Worldwide program helps Blue Cross and/or Blue Shield members arrange medical services when they are outside the United States. BlueCard Worldwide works differently than BlueCard inside the United States.

If you need to locate a doctor or hospital or need medical assistance services outside the United States, call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Except for emergencies, you cannot obtain services at the in-network cost-share from providers located outside the United States. Providers who are contracted with the BlueCard Worldwide program are out-of-network providers. If you receive covered services from a provider who is contracted with the BlueCard Worldwide program, you will pay out-of-network deductible and coinsurance and BCBSAZ access fees, plus the balance bill (except for emergency services).

- **Inpatient Services**

  In most cases, hospitals contracted with the BlueCard Worldwide program will not require you to pay for covered inpatient hospital services, except for your member cost-share (out-of-network deductible and coinsurance and BCBSAZ access fees). In such cases, the BlueCard Worldwide hospital will submit your claim for processing. **You must still contact BCBSAZ to obtain precertification for non-emergent inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the United States are generally not contracted with the BlueCard Worldwide program and will require you to pay for services in full at the time of service. Complete a BlueCard Worldwide claim form and send the claim form with the provider's bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claim processing. The claim form is available from BCBSAZ, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide.

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue. The amount you pay for covered healthcare services under a National Account arrangement will be calculated based on either: (1) the negotiated price made available to BCBSAZ by the Host Blue; or (2) the lesser of the provider's billed charges or the negotiated price made available to BCBSAZ by the Host Blue.

Services Received on Cruise Ships

If you receive health care services while on a cruise ship, you will pay in-network cost-share, and the allowed amount will be based on billed charges. A cruise ship claim is not considered an out-of-country claim. Claims should be submitted and processed through BCBSAZ, not through the BlueCard Worldwide program. Please call the BCBSAZ Customer Service department at the phone number listed in the front of this book for more information, or mail copies of your receipts to the BCBSAZ general correspondence address listed at the front of this book.

PRECERTIFICATION

Precertification

Precertification is the process BCBSAZ uses to determine eligibility for benefits.

When Is Precertification Required and What Happens If You Don't Obtain It

Not all services require precertification. Each benefit description in this booklet tells you whether precertification is required for that benefit. If it is required, your provider must obtain it on your behalf before rendering services.

Notwithstanding any other language in this benefit book, BCBSAZ may change the services that require precertification at any time. If the benefit description does not indicate that precertification is required, and you or your provider are unsure, go to www.azblue.com for a listing of medications and services that require precertification or call the Customer Service number listed in the front of this book.

If precertification is required, but not obtained, the consequences vary by benefit and network status of the provider. The benefit description section in this book tells you which consequences will apply to specific benefits including:

- Your benefits may be denied
- You may have to pay a precertification penalty
- Your cost-sharing payments may be substantially higher

How to Obtain Precertification

Ask your provider to contact BCBSAZ for precertification before you receive services. Your provider must contact BCBSAZ because he or she has the information and medical records we need to make a benefit determination. BCBSAZ will rely on information supplied by your provider. If that information is inaccurate or incomplete, it may affect the decision on your claim. You are responsible for checking with your provider to make sure that the provider has obtained any required precertification.

Factors BCBSAZ Considers in Evaluating a Precertification Request for Services or Medications

- Applicability of other benefit plan provisions (limitations, exclusions and benefit maximums);
- If the treating provider or location of service is in-network;
- Whether the service is medically necessary or investigational; **and**
- Whether your coverage is active.

Some of these factors may not be readily identifiable at the time of precertification, but will still apply if discovered later in the claim process and could result in denial of your claim.

Prescription Medication Exception

If a covered medication requires precertification, but you must obtain the medication outside of BCBSAZ's precertification hours, you may have to pay the entire cost of the medication when it is dispensed. In such cases, you can file a reimbursement claim with BCBSAZ and have your provider request precertification on the next business day. Your claim for the medication will not be denied for lack of precertification, but all other exclusions and limitations of your plan will apply.

Precertification of In-Network Cost-Share for Services from an Out-of-Network Provider

If there is no in-network provider available to deliver covered services, your treating provider may contact BCBSAZ and ask BCBSAZ to precertify the in-network cost-share for services from an out-of-network provider. BCBSAZ will evaluate whether there is an in-network alternative. If BCBSAZ determines that an in-network provider is available to treat you, BCBSAZ will not precertify in-network cost-share for services from your out-of-network provider of choice.

Precertification of in-network cost-share for services from an out-of-network provider is a process separate from precertification of services. If you want an out-of-network provider to render services that require precertification, and you also want to be eligible for the in-network cost-share, you must ensure that your

provider makes two separate precertification requests: one for the service itself and one for use of the out-of-network provider. The benefit descriptions in this book refer only to your obligation to obtain precertification for the service. If BCBSAZ precertifies you for the in-network cost-share, your services will be subject to the in-network cost-share. You will still be responsible for any balance bill, plus your in-network cost-share.

If BCBSAZ Precertifies Your Service

- Precertification is not a pre-approval or a guarantee of payment. Precertification made in error by BCBSAZ is not a waiver of BCBSAZ's right to deny payment for noncovered services.
- You and your provider will receive a letter explaining the scope of the precertification.

If BCBSAZ Denies Your Precertification Request

Denial of precertification is an adverse benefit determination. As explained in the next section on Claims, BCBSAZ will send you a notice explaining the reason for the denial, and your right to appeal the BCBSAZ decision. Information on where to file an appeal is in the BCBSAZ Customer Service section at the front of this book.

If your request for precertification of a service is denied because BCBSAZ decides that the service is not medically necessary, remember that BCBSAZ's interpretation of medical necessity is a benefits determination made in accordance with the provisions of this plan. Your provider may recommend services or treatment not covered under this plan. You and your provider should decide whether to proceed with the service or procedure if BCBSAZ denies precertification.

CLAIMS INFORMATION

Filing Claims

In most cases, in-network providers will file claims for you. Noncontracted providers may file your claims for you, but have no obligation to do so. Make sure you or your providers file all your claims so BCBSAZ can track your covered expenses and properly apply them toward applicable deductibles, coinsurance, out-of-pocket maximums and benefit maximums.

Time Limit for Claim Filing

A complete claim, as described below, must be filed within one year from the date of service. Any claim not filed within one year of the date of service may be denied.

Claim Forms

Claim forms are available from BCBSAZ. Go to the "Forms" section of the "Member" area of www.azblue.com or call the Supply Line telephone number listed at the front of this book.

Complete Claims

A complete claim includes, at a minimum, the following information:

- Billed charges
- Date of service(s)
- Diagnosis code
- Group number
- Member ID number
- Member name
- Name of provider
- Patient name
- Patient's birth date
- Procedure code
- Provider ID number
- Signature of provider who rendered services

BCBSAZ may reject claims that are filed without complete information needed for processing. If BCBSAZ rejects a submitted claim due to lack of information, BCBSAZ will notify you or the provider who submitted the claim. Lack of complete information may also delay processing.

Medical and Dental Records and Other Information Needed to Process a Claim

Even when the claim has all information listed above, BCBSAZ may need to request medical or dental records or coordination of benefits information to make a coverage determination. If BCBSAZ has requested medical records or other information from a third party, BCBSAZ will suspend claim processing while the request is pending. BCBSAZ may deny a claim for lack of timely receipt of requested records.

Explanation of Benefits (EOB) Form

After your claim is processed, BCBSAZ and/or any contracted vendors that process claims will send you an EOB. Your BCBSAZ EOBs also will be available through the member portal on www.azblue.com. An EOB shows services billed, whether the services are covered or not covered, the allowed amount and the application of cost-sharing amounts. Carefully review your EOB for any discrepancies or inconsistencies with the amounts your provider actually collects from you or bills to you. BCBSAZ and/or any contracted vendors will also send your in-network provider the information that appears on your EOB. This information is not sent to out-of-network providers. Out-of-network providers do not receive any written information on how much was paid on a claim or the reasons for how the claim processed. Save the EOB for your personal records. BCBSAZ or any contracted vendor may charge a fee for duplication of claims records.

Monthly Statement

Some EOBs may be consolidated and sent to you in the form of a monthly statement rather than as single EOBs.

Notice of Determination

If your request for precertification is denied, or your claim is denied in whole or in part, you will receive a notice of adverse benefit determination. In most cases, your EOB or monthly statement will serve as the notice, and will:

- State the specific reason(s) for the adverse benefit decision (e.g., not covered because the provider is ineligible or because services are not covered under this benefit plan),
- Reference the specific plan provision on which the determination is based,
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary,
- Describe applicable grievance/appeal procedures,
- Disclose any internal rule, guideline or protocol relied on in making the adverse determination (or state that such information is available free of charge upon request)
- If the denial is based on medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state the information will be provided free of charge upon request).

Time Period for Claim Decisions:

Post-Service Claims

Within thirty (30) days of receiving your claim for a service that was already rendered, BCBSAZ will send you an EOB adjudicating the claim, or a notice that BCBSAZ has requested records needed to make a decision on your claim.

If BCBSAZ cannot make a decision on your claim within thirty (30) days, BCBSAZ may extend the initial processing time by fifteen (15) days by notifying you, within the initial 30-day period, of the need for an extension, the expected decision date, and any additional information that may be needed for the decision. You or your provider will have at least forty-five (45) days to submit any requested information.

Pre-Service Claims

When you request coverage for a service that has not yet been rendered (precertification), BCBSAZ will make a precertification decision within a reasonable time period considering the medical circumstances, but not later than ten (10) business days from receipt of the precertification request.

If BCBSAZ requires more time to make a precertification decision, BCBSAZ may extend the time by an additional fifteen (15) days by notifying you, within the initial ten (10)-day period of need for an extension, the expected decision date, and any additional information needed for the decision. You and your provider will have at least forty-five (45) days to submit any requested information.

Concurrent Care Decisions

BCBSAZ may require that your provider submit a plan of care. Based on that plan, BCBSAZ may precertify a certain number of visits or services over a certain period of time. You may request precertification for additional periods of care as long as your request is made at least seventy-two (72) hours prior to the expiration of an existing plan of care. BCBSAZ will make a determination as soon as possible in accordance with medical exigencies, but no later than seventy-two (72) hours after receipt of the request. If that precertification is denied, you may appeal that denial in the same way you appeal any other coverage denial.

Urgent Claims

Federal law defines an “urgent” medical situation as the following: (a) one in which application of the “non-urgent” time periods could seriously jeopardize the member’s life, health or ability to regain maximum function **or** (b) one which, in the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

When you request coverage for an urgent care claim, a determination will be made as soon as possible in accordance with medical exigencies, but no later than seventy-two (72) hours after receipt of the request.

Appeal and Grievance Process

Members may participate in BCBSAZ's appeals and grievance processes, which are described in detail in the BCBSAZ Appeal and Grievance Guidelines, a separate document provided to you. You may obtain another copy of the BCBSAZ Appeal and Grievance Guidelines at any time by visiting us at www.azblue.comor by calling the BCBSAZ Supply Line telephone number listed in the front of this booklet.

You do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ. To appeal a denial of precertification for urgently needed services you have not yet received, please call the BCBSAZ Precertification Denial Appeals telephone number listed in the front of this booklet.

Billing Limitations and Exceptions

When there is another source of payment such as a liability insurer, in-network providers may be entitled to collect any difference between the allowed amount and the provider's billed charges from the other source or from proceeds received from the other source, pursuant to A.R.S. § 33-931.

A.R.S. § 33-931 may give providers medical lien rights independent of this benefit plan or any contract with BCBSAZ. BCBSAZ is not a party to any collection dispute that may arise under the provisions of A.R.S. § 33-931.

Blue Cross and Blue Shield Association

You hereby expressly acknowledge and agree to the following:

I. This benefit plan constitutes a contract between the Group and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSAZ to use the Blue Cross and/or Blue Shield service marks in the State of Arizona;
II. BCBSAZ is not contracting as the agent of the Association;
III. In accepting the benefits of this plan, you are not relying on any representations by the Association or any other Blue Cross or Blue Shield plan, other than BCBSAZ; **and**
IV. You will not seek to hold the Association or any Blue Cross and Blue Shield plan other than BCBSAZ, accountable or liable for BCBSAZ's obligations herein.

Broker Commissions

BCBSAZ sells health and dental coverage products either directly or through independent licensed insurance brokers. Commission payments to brokers are one of the costs factored into premiums, but BCBSAZ's premium calculation is not based on whether a product is sold directly or by a broker. BCBSAZ generally pays a commission to the broker of record or legal assignee designated by the broker until the insurance contract is terminated, the Group terminates its relationship with the broker and notifies BCBSAZ or the broker becomes ineligible for receipt of commissions. Brokers are required under their agreement with BCBSAZ to provide information on commission rates with BCBSAZ.

Claim Editing Procedures

In order to process claims accurately, BCBSAZ uses a computer system to verify benefits, eligibility, claims accuracy and compliance with BCBSAZ coding guidelines and the Medical Coverage Guidelines. BCBSAZ uses claims coding and editing logic to process professional and outpatient facility claims. This system logic is designed to identify the following: procedure unbundling (billing multiple procedure codes to represent a procedure that can be described with a more comprehensive code), separate billing for included (incidental) services, procedures not usually performed together (mutually exclusive) procedures, correct use of coding guidelines, member's age and sex edits. The system logic does not audit the diagnosis code to change or modify the intensity of service for office visit (evaluation and management) codes. BCBSAZ periodically updates its computer system claim edits.

Confidentiality and Release of Information

BCBSAZ takes confidentiality very seriously. We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with state and federal law. If you

wish to authorize someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from www.azblue.com or call BCBSAZ Customer Service and request a hard copy of the CIRF form.

Court or Administrative Orders Concerning Dependent Children

When a member is not the custodial parent of a child, but is required by a court or administrative order to provide health benefits to that child, BCBSAZ will provide benefit information to the custodial parent, permit the custodial parent to submit claims for the child and make payments directly to the custodial parent, provider or state agency as applicable.

Access to Information Concerning Dependent Children

BCBSAZ is not a party to domestic disputes. Parental disputes over Dependent coverage and information must be resolved between the parents of the Dependent child. Under Arizona law, both parents have equal rights of access to information about their children, unless there is a court order denying such access. Absent a copy of such order and subject to the confidentiality provisions described above, BCBSAZ provides equal parental access to information.

Discretionary Authority

BCBSAZ has discretionary authority to determine extent of coverage under the terms of this benefit plan.

Provider Treatment Decisions and Disclaimer of Liability

While rendering services to you, in-network providers are independent contractors and not employees, agents or representatives of BCBSAZ. Their contracts with BCBSAZ address reimbursement and administrative policies. Each provider exercises independent medical judgment in deciding what services to provide you, and how to provide them. BCBSAZ's role is limited to administration of the benefits under this benefit plan. Your provider may recommend services or treatment not covered under this benefit plan. You and your provider should decide whether to proceed with a service that is not covered.

BCBSAZ has no control over any diagnosis, treatment, care or other services rendered by any provider and disclaims any and all liability for any loss or injury to you caused by any provider by reason of the provider's negligence, failure to provide treatment or otherwise.

Lawsuits against BCBSAZ

BCBSAZ has an appeal process for resolving certain types of disputes with members. BCBSAZ encourages you to use the appeal process before filing a lawsuit, as issues can often be resolved when you give BCBSAZ more information through the appeal process.

Under Arizona's Health Care Insurer Liability Act, before suing BCBSAZ, a member must first either complete all available levels of the BCBSAZ appeal process or give BCBSAZ written notice of intent to sue at least thirty (30) days before filing the lawsuit. The written notice must set forth the basis for the lawsuit and must be sent by certified mail to the following address:

Attn: Legal Department
Mail Stop: C300
Blue Cross Blue Shield of Arizona, Inc.
8220 N. 23rd Avenue
Phoenix, AZ 85021-4872

Failure to comply with these provisions may result in dismissal of the lawsuit.

A member must complete all applicable levels of appeal before bringing a lawsuit other than a suit filed pursuant to the Health Care Insurer Liability Act. Failure to complete the mandatory levels of the appeal process may result in dismissal of the lawsuit for failure to exhaust BCBSAZ's administrative remedies.

By providing this notice BCBSAZ does not waive, but expressly reserves all applicable defenses available under Arizona and federal law.

Legal Action and Applicable Law

This contract is governed by, construed and enforced in accordance with the laws of the state of Arizona, without regard to conflict of laws, principles, and applicable federal law.

This benefit book and the contract between BCBSAZ and the sponsor of your group health plan were issued in Arizona to a group headquartered in Arizona. The only state law governing the benefit book and the contract is the law of the state of Arizona. This benefit plan may not provide all benefits required by other state laws.

Jurisdiction and Venue

Maricopa County, Arizona shall be the site of jurisdiction and venue for any legal action or other proceeding that arises out of or relates to the contract or this benefit plan.

Lawsuits by BCBSAZ

Sometimes, BCBSAZ has an opportunity to join class action lawsuits, where third party payers (insurance companies) assert that an entity's conduct resulted in higher payments by the insurance company than otherwise would have been required. BCBSAZ reviews these cases and makes a good faith decision based on the unique facts of each case whether to join the case. BCBSAZ may also bring lawsuits against vendors or other entities to recover various economic damages. When BCBSAZ participates as a plaintiff and recovers damages, those funds are not returned to individual members, but are instead retained by BCBSAZ to reduce overall administrative costs. This paragraph is not intended to limit or waive any claims BCBSAZ may have against any person or entity.

Non-Assignability of Benefits

The benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against BCBSAZ and imposes no duty or obligation on BCBSAZ.BCBSAZ will not honor any such purported sale, assignment, pledge, transfer or grant.

Medicaid Reimbursement

Member acknowledges that state Medicaid agencies, including the Arizona Health Care Cost Containment System ("AHCCCS"), (collectively referred to as "Medicaid Agencies") are considered payers of last resort for health care expenses of individuals who are Medicaid beneficiaries. Member further acknowledges that AHCCCS does, and other state Medicaid Agencies may, have a legal right to reimbursement of expenditures that the Medicaid Agencies have made on behalf of a member who was also a Medicaid Beneficiary, not to exceed the lesser of the member's benefits under this plan or the Medicaid Agencies' payment. Member acknowledges and agrees that BCBSAZ shall reimburse Medicaid Agencies or their designees, for the health claims of a member who was also a Medicaid Beneficiary on the date of service, to the extent required by law.

Member Notices and Communications

BCBSAZ sends notices and other communications to members by U.S. mail to the last address on file with BCBSAZ Membership Services. BCBSAZ may also elect to send some notices and communications electronically if the member has consented to electronic receipt. Notice is deemed complete when sent to the member's last address of record, as follows: (1) on delivery, if hand-delivered; (2) if mailed, on the earlier of the day actually received by the member or five days after deposit in the U.S. mail, postage prepaid; or (3) if transmitted electronically, on the earlier of the day of actual receipt or 24 hours after electronic transmission to the member's email address of record.

Payments Made in Error

If BCBSAZ erroneously makes a payment or over-payment to you or on your behalf, BCBSAZ may obtain reimbursement from you or the provider or BCBSAZ may offset the amount owed against a future claim arising from any covered service. Payments made in error by BCBSAZ do not constitute a waiver concerning the claim(s) at issue or of any right of BCBSAZ to deny payment for noncovered services.

Plan Amendment

There is no guarantee of continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted or changed upon notice to the Group and/or Contractholder and/or participant or as required to comply with state or federal laws. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the employer group. At the time of renewal, if your Group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available. Please review and retain this book, any replacement books, any SBCs, all riders and amendments and other communications concerning your coverage.

Retroactive Changes

BCBSAZ reserves the right to make certain retroactive amendments to this benefit plan, as may be permitted under applicable federal and state law. You will receive notice of any such amendments.

Provider Contractual Arrangements

The BCBSAZ allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors such as type and location of provider and other relevant information. For that reason, BCBSAZ network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate. This means that your in-network cost-share for a particular service can vary based on the network provider you choose because not all providers have the same negotiated reimbursement rate for the same service.

Release of Records

Subject to Arizona or federal law, the member agrees that BCBSAZ may obtain, from any provider, insurance company or third party, all records or information relating to the member's health, condition, treatment, prior health insurance claims or health benefit program. A failure to provide records needed to adjudicate a claim can result in denial of the claim.

Rescission of Coverage

In the event of fraud or intentional misrepresentation of material fact, coverage for any person ineligible to be on the benefit plan as described in the Group Master Contract will be rescinded, that is, as never having been in effect. Premiums paid for the coverage for the ineligible person will be refunded, minus any claims paid for that person. BCBSAZ is entitled to recover claim payments that exceed the amount of premium paid. Such rescission does not affect the coverage of those persons on the benefit plan who remain eligible for coverage.

BCBSAZ will give 30 days' written notice of its intent to rescind, during which time the person may protest the decision by writing to BCBSAZ at the address indicated in the notice and explaining why a rescission is not appropriate or allowable.

A member's eligibility to enroll in the group's health plan is not based on the member's health status. An omission or misrepresentation of health information in your application for group coverage is not a basis for rescission of your group coverage.

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. In-network providers generally cannot charge you for providing BCBSAZ with health records needed to process claims, grievances or appeals. Noncontracted providers have no contractual obligation to provide records to BCBSAZ free of charge. If you receive services from a noncontracted provider who charges for record preparation, costs or copies, you will need to make arrangements with your provider to obtain any records required by BCBSAZ and pay any applicable fees.

Third-Party Beneficiaries

The provisions of this benefit plan are only for the benefit of those covered under this plan. Except as may be expressly set forth in this book, no third party may seek to enforce or benefit from any provisions of this benefit plan.

Your Right to Information; Availability of Notice of Privacy Practices

You have the right to inspect and copy your information and records maintained by BCBSAZ, with some limited exceptions required by law. If you choose to review your medical records in person, BCBSAZ will require a reasonable amount of time to research and retrieve the records before scheduling a time with you to review the records.

The BCBSAZ "Notice of Privacy Practices" describes how BCBSAZ may use and disclose your information to administer your health plan. It also describes some of your individual rights and BCBSAZ's responsibilities under federal privacy regulations. BCBSAZ mails a copy of this Notice of Privacy Practices to your address shortly after you enroll for coverage with BCBSAZ.

You can also view the "Notice of Privacy Practices" by visiting the BCBSAZ website, www.azblue.com, and clicking on the Privacy Statement link at the bottom of the home page.

If you would like BCBSAZ to mail you another copy of the "Notice of Privacy Practices," please call the Customer Service telephone number listed on the back of your BCBSAZ identification card, or call (602) 864-4400 or (800) 232-2345 to make your request.

Subrogation

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") that provides its employees and their dependents ("Participants") with health care coverage.

BCBSAZ performs claims administration for the Plan and now also provides subrogation recovery services for the Plan as described in this section.

Here is the way subrogation works. Sometimes you and/or your dependent ("you") require hospital and/or medical services due to an injury in an accident or due to a condition caused by another person's negligence. In such cases, the person causing the accident ("third party") is responsible for payment of your hospital and medical expenses. The Plan, who pays for your covered hospital and medical services, has the right to recover these payments from the third party or from you if you have recovered from the third party. When the Plan exercises its rights to be reimbursed, the process is known as subrogation, recovery and/or reimbursement ("subrogation").

During the subrogation process, BCBSAZ, on behalf of the Plan, will continue to pay your covered hospital and medical services on behalf of the Plan just as it always has. However, if a third party is legally obligated to pay for your expenses, the Plan will then exercise its rights to be reimbursed for 100 percent of what the Plan paid without any reduction for attorneys' fees and/or court costs and regardless of whether you were made whole. In addition, the Plan has first priority from any judgment, payment or settlement.

The Plan's rights apply to any settlement of a claim regardless of whether anyone has started litigation. Any right a Participant might have to be "made whole",(i.e., to be fully compensated for his/her injuries prior to any right the Plan has to recover its cost) is superseded by the Plan's subrogation rights. The Plan may subrogate against all money that you or anyone recovers regardless of the source of the money and regardless of where the money is located and/or regardless of how it is held. The Plan will also have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of recovery or settlement.

You must promptly execute and deliver any documents relating to settlement of claims, settlement negotiations or litigation when the Plan asks you to so the Plan can exercise its subrogation rights. Also, you or your legal representative must (1) promptly notify the Plan in writing of any settlement negotiations before you enter into any settlement agreement, (2) disclose to the Plan any amount recovered from any person or entity that may be liable and (3) not make any distributions of settlement or judgment proceeds without the Plan's prior written consent. No waiver, release of liability or other documents executed by you without such written notice to the Plan shall be binding upon the Plan.

MEMBER COST-SHARING

Members pay part of the costs for benefits received under this plan. Depending on your particular benefit plan, the service you receive and the provider you choose, you may have an access fee, balance bill, coinsurance, copay, deductible or some combination of these payments. Each cost-share type is explained below. This section, the benefit descriptions in this book and your SBC will explain which cost-share types apply to each benefit.

BCBSAZ uses your claims to track whether you have met some cost-share obligations. We apply claims based on the order in which we process the claims and not based on date of service.

Access Fee

An access fee is a fixed fee you pay to a provider for certain covered services, usually at the time of service. If an access fee applies to a particular service, you must pay the access fee plus any other applicable cost-share for the service. Access fees do not count toward meeting your calendar-year deductible.

Balance Bill

The balance bill refers to the amount you may be charged for the difference between a noncontracted provider's billed charges and the allowed amount.

Noncontracted providers have no obligation to accept the allowed amount. You are responsible to pay a noncontracted provider's billed charges, even though BCBSAZ will reimburse your claims based on the allowed amount. Depending on what billing arrangements you make with a noncontracted provider, the provider may charge you for full billed charges at the time of service or seek to balance bill you for the difference between billed charges and the amount that BCBSAZ reimburses you on a claim.

Any amounts paid for balance bills do not count toward deductible, coinsurance or the out-of-pocket maximum.

Benefit Maximums

Some benefits may have a specific benefit maximum or limit based on the number of days or visits, type, timeframe (calendar year or benefit plan), age, gender or other factors. If you reach a benefit maximum, any further services are not covered under that benefit and you may have to pay the provider's billed charges for those services. However, if you reach the benefit maximum on a particular line of a claim, you will be responsible for paying only up to the allowed amount for the remaining charges on that line of the claim. All benefit maximums are included in the applicable benefit description.

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for covered services each January through December before the benefit plan begins to pay for covered services. The deductible applies to every covered service unless the specific benefit section says it does not apply.

If you have family coverage, there is also a calendar-year deductible for the family. Amounts counting toward an individual's calendar-year deductible will also count toward any family deductible. When the family satisfies its calendar-year deductible, it also satisfies the deductible for all the individual members. An individual member cannot contribute more than his or her individual deductible toward the family's deductible.

The deductible is calculated based on the allowed amount. Amounts you pay for copays and access fees do not count toward the deductible.

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for certain covered services after meeting any applicable deductible. BCBSAZ subtracts any applicable access fees and precertification charges from the allowed amount before calculating coinsurance. Coinsurance applies to every covered service unless the specific benefit section says it does not apply.

BCBSAZ normally calculates coinsurance based on the allowed amount. There is one exception. If a hospital provider's billed charges are less than the hospital's DRG reimbursement, BCBSAZ will calculate your coinsurance based on the lesser billed charge.

Copay

A copay is a specific dollar amount you must pay to the provider for some covered services. If a copay applies to a covered service, you must pay it when you receive services. Different services may have different copay amounts and are shown on your SBC. Usually, if a copay does not apply, you will pay applicable deductible and coinsurance.

Out-of-Pocket Maximum (Individual & Family)

An out-of-pocket maximum is the amount each member must pay each year before the plan begins paying 100 percent of the allowed amount on covered services, for the remainder of the calendar year. The payments listed below do not count toward the out-of-pocket maximum. You must keep paying them even after you reach your out-of-pocket maximum:

- Amounts above a benefit maximum
- Any amounts for balance billing
- Any amounts for noncovered services
- Any charges for lack of precertification

If you have family coverage, there is an out-of-pocket maximum for your family. Amounts applied to each member's out-of-pocket maximum also apply to the family out-of-pocket maximum. The family maximum is applied in the same way as the individual maximum described above and is subject to the same rules. When the family has met its family out-of-pocket maximum, it also satisfies the out-of-pocket maximum requirements for all the individual members.

Precertification Charges

You must make sure that your provider obtains precertification from BCBSAZ for any service that requires it. Otherwise, you are subject to a precertification charge or complete loss of your benefit, depending on the plan. Applicable precertification charges are shown on your SBC.

BCBSAZ will send your provider a letter, with a copy to you, to confirm that BCBSAZ has precertified a service. If you are not sure whether your service needs precertification or if your provider has precertified your service, you can call BCBSAZ customer service at the number listed on your ID card or the front of this book.

Amounts applied as precertification charges do **not** count toward the calendar-year deductible or out-of-pocket maximum.

DESCRIPTION OF BENEFITS

Please review this section for an explanation of covered services and benefit-specific limitations and exclusions. Also be sure to review *"What is Not Covered"* for general exclusions and limitations that apply to all benefits.

To be covered and eligible for benefits, a service must be:

- A benefit of this plan;
- Medically necessary as determined by BCBSAZ or BCBSAZ's contracted vendor;
- Not excluded;
- Not experimental or investigational as determined by BCBSAZ or BCBSAZ's contracted vendor;
- Precertified if precertification is required;
- Provided while this benefit plan is in effect and while the person claiming benefits is an eligible member; **and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ.

BCBSAZ does not determine whether a service is covered under this benefit plan until after services are provided, and BCBSAZ receives a complete claim describing the services actually provided.

The SBC sent with your member ID card shows the actual cost-share amounts for the cost-share types shown for each benefit, such as deductible amounts, copays, and coinsurance percentages.

A. AMBULANCE SERVICES

Precertification: Not required.

Your Cost-Share: You pay in-network deductible and coinsurance.

Benefit Description: Ground ambulance transportation from the site of an emergency, accident or acute illness to the nearest facility capable of providing appropriate treatment; **or**

Interfacility ground or air ambulance transfer for admission to an acute care facility, extended active rehabilitation facility or skilled nursing facility when the transferring facility is unable to provide the level of service required; **or**

Air ambulance transportation to the nearest facility capable of providing appropriate treatment when the emergency, accident or acute illness occurs in an area inaccessible by ground vehicles or transport by ground ambulance would be harmful to the member's medical condition.

Benefit-Specific Exclusion: All other expenses for travel and transportation are not covered, except for the benefits described in "*Transplant Travel and Lodging*."

B. BEHAVIORAL AND MENTAL HEALTH SERVICES (including chemical dependency or substance abuse treatment)

Behavioral and Mental Health Services (Outpatient Facility and Professional Services):

Precertification: Not required.

Your Cost-Share:

In-Network: You pay one copay per member, per provider, per day, then the Plan pays 100 percent of the allowed amount.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Non-emergency outpatient behavioral and mental health services are available from in- and out-of-network providers. Those services include psychotherapy, outpatient therapy services (including intensive outpatient rehabilitative therapy) for chemical dependency or substance abuse, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications and electroconvulsive therapy.

Conditions Applicable to Services from In- and Out-of-Network Providers:

Benefits for outpatient behavioral and mental health services delivered by in- and out-of-network providers are limited to a maximum of twenty (20) visits per member, per calendar year. Benefits for outpatient chemical dependency are limited to a second, separate maximum of twenty (20) visits per member, per calendar year. Benefits for intensive outpatient rehabilitive therapy are limited to a third, separate maximum of twenty (20) visits per member, per calendar year. Visits to both in-network and out-of-network providers count toward the twenty (20) visit limit(s). Covered electroconvulsive therapy (ECT) services are not subject to the twenty (20) visit limit(s).

Behavioral and Mental Health Services (Inpatient and Partial Hospitalization):

Precertification: Required for non-emergency inpatient behavioral and mental health admissions. If you fail to obtain precertification, you will be responsible for a precertification charge.

Your Cost-Share:

In-Network Facility and Professional Services: You pay in-network deductible and coinsurance.

Out-of-Network Facility and Professional Services: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Inpatient facility and professional behavioral and mental health services are limited to a combined total maximum of thirty (30) days per member, per calendar year. Both in- and out-of-network admissions count toward the thirty (30) day limit. Inpatient behavioral and mental health professional services also are covered.

Partial Hospitalization: Two (2) days of partial hospitalization equals 1 day of inpatient care.

If you receive both detoxification services and inpatient behavioral and mental health therapy services during the same admission in a facility that provides both acute medical treatment and inpatient behavioral and mental health therapy (either concurrently or subsequent to the detoxification services), the entire admission will be covered under the “Inpatient Detoxification” benefit.

Behavioral and Mental Health Emergency Services (Professional and Facility Charges):

Precertification: Not required.

Your Cost-Share: For emergency services, you will pay your in-network cost-share, even for services received from out-of-network providers. You pay the emergency room access fee per member, per provider, per day, plus in-network deductible and coinsurance for emergency professional, ancillary and facility charges. If you are admitted to the hospital, the access fee is waived and cost-sharing for inpatient behavioral and mental health admissions applies. If you receive emergency services from a noncontracted provider BCBSAZ will base the allowed amount used to calculate your cost-share on billed charges.

For all non-emergency services following the emergency treatment and stabilization, you pay applicable deductible, coinsurance, copays and access fees. The cost-share amount will depend on the provider’s network status and the place you receive services. If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which may be substantial.

Benefit Description: Benefits are available for emergency behavioral and mental health services.

Behavioral Therapy Services For The Treatment Of Autism Spectrum Disorder

Precertification: Required. If you fail to obtain precertification, behavioral therapy services for the treatment of autism spectrum disorder will not be covered.

Your Cost-Share:

In-Network: You pay one copay per member, per provider, per day, then the Plan pays 100 percent of the allowed amount.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) and autism are limited to the initial diagnosis, medication management, and one (1) evaluation per member, per calendar year.

Benefit-Specific Definitions:

"Autism Spectrum Disorder" means Autistic Disorder, Asperger's Syndrome, or Pervasive Developmental Disorder (not otherwise specified), as defined in the BCBSAZ Medical Coverage Guidelines and referenced in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral Therapy" means interactive therapies derived from evidence-based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

Benefit Description: Behavioral therapy services for the treatment of Autism Spectrum Disorder are available for members who have been diagnosed with Autism Spectrum Disorder. Services are available from in- and out-of-network providers. Covered behavioral therapy services must be delivered by a provider who is licensed or certified as required by law.

Benefit Maximum for All Behavioral and Mental Health Services:

Inpatient behavioral and mental health admissions are limited to a combined maximum total of thirty (30) days per member, per calendar year. Outpatient behavioral and mental health visits to in- and out-of-network providers are limited to twenty (20) visits per member, per calendar year (limit does not apply to covered ECT services). Benefits for outpatient chemical dependency are limited to a second, separate maximum of twenty (20) visits per member, per calendar year. Benefits for intensive outpatient rehabilitive therapy are limited to a third, separate maximum of twenty (20) visits per member, per calendar year. Covered electroconvulsive therapy (ECT) services are not subject to the twenty (20) visit limit(s).

Laboratory, radiology and certain diagnostic procedures are treated as medical services even when a behavioral and mental health care diagnosis is indicated and are not subject to the mental and behavioral health benefit limits indicated above.

Benefit- Specific Exclusions (applicable to all Behavioral and Mental Health Services):

- Activity therapy, milieu therapy and any care primarily intended to assist an individual in the activities of daily living
- Biofeedback services provided by out-of-network providers
- Development of a learning plan and treatment and education for learning disabilities (such as reading and arithmetic disorders)
- Hypnotherapy
- IQ testing
- Lifestyle education and management services
- Neurofeedback
- Neuropsychological and cognitive testing
- Inpatient and outpatient facility charges for services provided by the following facilities are not covered: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes. Inpatient and outpatient facility charges for services provided by residential treatment facilities are not covered except for very limited situations based upon BCBSAZ medical necessity criteria. All other inpatient and outpatient services provided by residential treatment facilities are not covered.
- Sensory integration, LOVAAS therapy and music therapy

C. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

Precertification: Not required.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for outpatient Phase I and II cardiac rehabilitation programs and pulmonary rehabilitation services.

D. CATARACT SURGERY AND KERATOCONUS

Precertification: Required for inpatient cataract surgery. If you fail to obtain precertification, you will be responsible for a precertification penalty.

Your Cost-Share: You pay applicable deductible, coinsurance and copays for the cataract surgery and any associated services. The cost-share amount will depend on the provider's network status and the place you receive services. In addition, you pay any amounts above the $250 maximum per member, per six (6) month period, for eyeglasses. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: There is a maximum benefit of $250 per member, per six (6) month period for eyeglasses following cataract surgery.

Benefit Description: Benefits are available for the removal of cataracts, including placement of a single intraocular lens at the time of the cataract removal. Benefits are also available for the first pair of external contact lenses or eyeglasses post-cataract surgery or for treatment of keratoconus. The eyeglasses or external contact lenses must be prescribed and purchased within six (6) months of the surgery.

Benefit-Specific Exclusion: Procedures associated with cataract surgery that are not included in the benefit description, including replacement, piggyback or secondary intraocular lenses and any other treatments or devices for refractive correction.

E. CHIROPRACTIC SERVICES

Precertification: Not required.

Your Cost-Share:

In-Network: You pay one copay, per member, per provider, per day for chiropractic services, including but not limited to, physical therapy services provided by a chiropractor.

Out-of-Network: You pay out-of-network deductible and coinsurance for services rendered by an out-of-network provider. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for chiropractic services.

Benefit-Specific Exclusions:

- Massage therapy
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Spinal decompression
- Vertebral axial decompression therapy (VAX-D)

F. CLINICAL TRIALS FOR TREATMENT OF CANCER AND OTHER LIFE-THREATENING DISEASES

Precertification: Required for services directly associated with a clinical trial for treatment of cancer or other life-threatening diseases or conditions. Precertification will be issued in accordance with the requirements of applicable law, regardless of whether the clinical trial would otherwise be considered investigational. See specific benefit provisions for precertification charges.

Precertification of covered services directly associated with an eligible clinical trial is not a guarantee of coverage, assurance that the clinical trial satisfies the requirements of applicable law or evidence of any determination that the service provided through the clinical trial is safe, effective or appropriate for any member.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: A "life-threatening disease or condition" is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefit Description: Benefits are available for covered services directly associated with a member's participation in a clinical trial meeting all requirements specified by applicable Arizona and/or federal law. Benefits are limited to those services eligible for coverage under this plan that would be required if you received standard, non-investigational treatment. If you have any questions about whether a particular service will be covered, please contact BCBSAZ customer service. You or your provider must inform BCBSAZ that you are enrolled in a clinical trial, that the trial meets the requirements of applicable law, and that the services to be rendered are directly associated with the trial. Otherwise, BCBSAZ will administer your benefits according to the other terms of your benefit plan, which may result in a denial of benefits.

Benefit-Specific Exclusions:

- Investigational medications and devices
- Any item, device or service that is the subject of the clinical study, or which is provided solely to meet the need for data collection and analysis
- Costs and services customarily paid for by government, biotechnical, pharmaceutical and medical device industry sources
- Costs to manage the clinical trial research
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services not otherwise covered under this plan

G. DENTAL SERVICES BENEFIT - MEDICAL

Not all dentists who are contracted with BCBSAZ are contracted to provide medical-related dental services. Call BCBSAZ Customer Service with questions.

G.1 Dental Accident Services

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definitions: "Accidental dental injury" is an injury to the structures of the teeth that is caused by an external force or element such as a blow or fall. An injury to a tooth while chewing is not considered an accidental dental injury, even if the injury is due to chewing on a foreign object.

A "sound tooth" is a tooth that is:

- Whole or virgin; **or**
- Restored with amalgam (silver filling) or composite resin (tooth-colored filling) or restored by cast metal, ceramic/resin-to-metal or laboratory processed resin/porcelain restorations (crowns); **and**
- Without current periodontal (tissue supporting the tooth) disease or current endodontal (tooth pulp or root) disease; **and**
- Not in need of the treatment provided for any reason other than as the result of an accidental dental injury.

Benefit Description: Benefits are available only for the following services to repair or replace sound teeth damaged or lost by an accidental dental injury:

- Extraction of teeth damaged as a result of accidental dental injury
- Original placement of fixed or removable complete or partial dentures
- Original placement, repair or replacement of crowns
- Original placement, repair or replacement of veneers
- Orthodontic services directly related to a covered accidental injury

Benefit-Specific Exclusions:

- Gold foil restorations or inlays
- Occlusal rehabilitation and reconstruction
- Original placement, repair or replacement of dental implants and any related services
- Repair and replacement of fixed or removable complete or partial dentures
- Routine dental care
- Routine extractions

G.2 Dental Services Required for Medical Procedures

Precertification: Required for non-emergency inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification penalty.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for dental services required to perform the medical services listed in this benefit. These dental services may either be part of the medical procedure or may be performed in conjunction with and made medically necessary solely because of the medical procedure:

- Diagnostic services prior to planned organ or stem cell transplantation procedures
- Removal of teeth required for covered treatment of head and neck cancer or osteomyelitis of the jaw
- Restoration of teeth made medically necessary because of the covered treatment of head and neck cancer or osteomyelitis of the jaw

Benefit-Specific Exclusions:

- Dental implants and any related services
- Gold foil restorations and inlays
- Occlusal rehabilitation and reconstruction
- Orthodontic services
- Routine dental care
- Routine extractions
- Repair and replacement of fixed or removable complete or partial dentures

G.3 Medical Services Required for Dental Procedures (Facility and Professional Anesthesia Charges)

Precertification: Required for non-emergency inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification penalty.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for facility and professional anesthesiologist charges incurred to perform dental services under anesthesia in an inpatient or outpatient facility for a patient having one or more of the following concurrent or co-morbid conditions:

- Children 5 years or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office
- Malignant hypertension
- Mental retardation
- Senility or dementia

- Unstable cardiovascular condition
- Uncontrolled seizure disorder

H. DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS

Precertification: Not required.

Your Cost-Share: You pay applicable deductible, coinsurance and copays. Your cost-share is waived for one FDA-approved manual or electric breast pump and breast pump supplies per female member, per calendar year. You also pay the balance bill for services provided by noncontracted providers.

H.1 Durable Medical Equipment (DME)

Benefit Description: To be eligible for coverage, DME must meet all of the following criteria:

- Be designed for repeated medical use in the home setting;
- Be specifically designed to improve or support the function of a body part;
- Cannot be primarily useful to a person in the absence of an illness or injury; **and**
- Intended to prevent further deterioration of the medical condition for which the equipment has been prescribed.

Benefits are available for DME rental up to the purchase price of the item, as determined by BCBSAZ, and for DME repair or replacement due to normal wear and tear caused by use of the item in accordance with the manufacturer's instructions or due to growth of a child. Benefits are limited to the allowed amount for the DME item base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded DME items may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusions:

- Charges for continued rental of a DME item after the purchase price is reached
- Repair costs that exceed the replacement cost of the DME item
- Repair or replacement of DME items lost or damaged due to neglect or use that is not in accordance with the manufacturer's instructions or specifications

H.2 Medical Supplies

Benefit Description: Benefits are available for the following medical supplies:

- A device or supply required by applicable law or as otherwise permitted under the Medical Coverage Guidelines
- Diabetic injection aids and drawing-up devices
- Diabetic syringes and lancets
- Insulin pumps and insulin pump supplies
- Ostomy and urinary catheter supplies
- Peak flow meters
- Supplies associated with oxygen or respiratory equipment
- Test strips for glucose monitors and urine test strips
- Volume nebulizers

Benefits are limited to the allowed amount for the medical supply base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded medical supplies may be eligible for coverage based upon BCBSAZ medical necessity criteria.

H.3 Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- Prosthetic appliances to replace all or part of the function of an inoperative or malfunctioning body organ or to replace an eye or limb lost as a result of trauma or disease

- Orthotics (such as foot orthotics, collars, braces, molds) to protect, restore or improve impaired bodily function
- Wig(s) for individuals diagnosed with alopecia (absence of hair) resulting from illness or injury (up to a maximum benefit of $300 per member, per calendar year)
- Orthopedic shoes that are:

    - attached to a brace; **and**
    - therapeutic shoes (depth inlay or custom-molded) along with inserts, for individuals with diabetes; **and**
    - covered in accordance with BCBSAZ medical necessity criteria.

Benefits are limited to the allowed amount for the prosthetic appliance or orthotic base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded prosthetic appliances or orthotics may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusions for all Durable Medical Equipment, Medical Supplies and Prosthetic Appliances and Orthotics:

- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, corsets, cushions, dentures, diatherapy machines, disposable hygienic items, dressing aids and devices, elastic/support/compression stockings except TED hose, elevators, exercise equipment, foot stools, garter belts, grab bars, health spas, hearing aid batteries, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, mineral baths, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas and vehicle or home modifications.
- Blood glucose monitors of any kind
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for help in daily living, socialization, personal comfort, convenience or other nonmedical reasons
- Manual and electric breast pumps and supplies for male members
- Replacement of external prosthetic devices due to loss or theft
- Strollers of any kind
- Supplies used by a provider during office treatments
- Tilt or inversion tables or suspension devices
- Wig(s), when hair loss results from male or female-pattern baldness or natural or premature aging

I. EDUCATION AND TRAINING

Precertification: Not required.

I.1 Diabetes and Asthma Education and Training

Your Cost-Share: Waived.

Benefit Description: Benefits are available for diabetes and asthma education and training from in-network providers whose services are:

- Provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Conducted in person; **and**
- Prescribed by a patient's health care provider as part of a comprehensive plan of care to enhance therapy compliance and improve self-management skills and knowledge for a patient diagnosed with diabetes or asthma.

Benefit-Specific Exclusion: Diabetes and asthma education and training provided by out-of-network providers.

I.2 Nutritional Counseling and Training

Your Cost-Share: Applicable deductible, coinsurance and copays are waived for services from an in-network provider. You pay out-of-network deductible and coinsurance for services from an out-of-network provider. If you receive services from a noncontracted provider, you pay the balance bill.

Benefit Description: Nutritional counseling and training is available from in-network providers for members diagnosed with one or more of the following conditions:

- Coronary Artery Disease
- Heart Failure
- High Cholesterol
- Hypertension
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

J. EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)

Precertification: Not required.

Your Cost-Share: For emergency services, you will pay your in-network cost share, even for services from out-of-network providers.

Emergency Room: You pay one access fee per member, per facility, per day plus in-network deductible and coinsurance.

Admission to the Hospital from the Emergency Room: The emergency room access fee is waived if you are admitted to the hospital. Following admission, you pay in-network deductible and coinsurance for all other hospital and professional services related to the emergency.

If you receive emergency services from a noncontracted facility or professional provider, BCBSAZ will base the allowed amount used to calculate your cost-share on billed charges.

For all non-emergency services following the emergency treatment and stabilization, you pay applicable deductible, coinsurance, copays and access fees. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which may be substantial.

Benefit Description: Benefits are available for services needed to treat an Emergency Medical Condition, and teletrauma consultation services that meet the following criteria:

- The teletrauma consultation is between a provider at the facility where the member is physically located and being treated by one or more providers at certain Level 1 trauma centers.
- The member is receiving emergency treatment in a facility that is not equipped to handle the member's medical condition;
- The treating provider needs the consultation to appropriately treat or stabilize the member.

Benefit-Specific Definitions: "Teletrauma consultation" means telephonic or electronic communications between providers and video presentation of the member's condition between providers, where all consulting providers are located in facilities with the specialized equipment needed to facilitate teletrauma communications.

"Trauma" means a physical wound or injury that results from a sudden accident or violent cause and which, if not immediately treated, is likely to result in death, permanent disability or severe pain.

K. EOSINOPHILIC GASTROINTESTINAL DISORDER

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and 20 percent of the Cost of amino-acid based formula ('Formula").

Benefit-Specific Definition: "Cost" is defined as either billed charges, if the Formula is purchased from an out-of-network provider, or the allowed amount, if purchased from an in-network provider.

Benefit Description: Benefits are available for Formula for members who are:

- At risk of mental or physical impairment if deprived of the Formula;
- Diagnosed with eosinophilic gastrointestinal disorder; **and**
- Under the continuous supervision of a physician or a registered nurse practitioner.

L. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Precertification: Required for inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification penalty.

Your Cost-Share:

In-Network:

Implanted Devices: Your cost-share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved implanted contraceptive devices for female members when the purpose of the procedure is contraception, as documented by your provider on the claim, and the device is inserted and/or removed in an in-network physician office. You pay applicable in-network cost-share when the location of service is outside an in-network physician office.

Sterilization Procedures: Your cost-share is waived for professional and facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim.

You pay applicable in-network cost-share for FDA-approved sterilization procedures provided to male members.

Hormonal Contraceptive Methods: Your cost-share is waived for oral contraceptives, patches, rings and contraceptive injections. See the "Physician Services" section for benefits.

Emergency Contraception: Your cost-share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a physician or other provider. See the "Physician Services" section for benefits.

Barrier Contraceptive Methods: Your cost-share is waived for diaphragms, cervical caps, cervical shields, female condoms and sponges and spermicides for female members. See the "Physician Services" section for benefits.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for FDA-approved contraceptive methods and devices and sterilization procedures when prescribed by the member's provider.

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.

M. HEARING SERVICES

Precertification: Not required.

Your Cost-Share: You pay one (1) copay per member, per provider, per day for hearing exams received from in-network providers. You pay out-of-network deductible and coinsurance for hearing exams received from out-of-network providers. You pay applicable deductible and coinsurance for hearing aids received from in- and out-of-network providers. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Maximum: There is a benefit maximum of one (1) hearing aid per member, per ear, per calendar year.

Benefit Description: Hearing exams, aids, services and supplies.

To receive reimbursement for hearing aids, services or supplies received from a noncontracted provider, you must submit a claim form to BCBSAZ.

N. HOME HEALTH SERVICES

Precertification: Required for certain medications covered under this benefit. Go to www.azblue.com for a listing of medications that require precertification or call the customer service number listed in the front of this book. If you fail to obtain precertification for these medications, they will not be covered.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: "Sole source of nutrition" is defined as the inability to orally receive more than 30 percent of daily caloric needs.

Benefit Maximum: There is a combined in- and out-of-network limit of 60 visits, per member, per calendar year.

Benefit Description: Benefits are available for the following services:

- Home infusion medication administration therapy, including:
  - Blood and blood components
  - Hydration therapy
  - Intravenous catheter care
  - Intravenous, intramuscular or subcutaneous administration of medication
  - Specialty injectable medications, as defined by BCBSAZ
  - Total parenteral nutrition
- Enteral nutrition (tube feeding) when it is the sole source of nutrition.
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition and other services that require skilled nursing care.

Each service must meet all of the following criteria:

- A licensed home health agency must provide the service in the member's residence;
- A health care provider must order the service pursuant to a specific plan of home treatment;
- The health care provider must review the appropriateness of the service at least once every thirty (30) days or more frequently if appropriate under the treatment plan; **and**
- The service must be provided by a licensed practical nurse (L.P.N.) or a registered nurse (R.N.) or another eligible provider.

Benefit-Specific Exclusions:

- All services in excess of the sixty (60) visit limit described in this section
- Continuous home health services or shift nursing, including 24 hour continuous nursing care.
- Custodial Care
- Private Duty Nursing
- Respite Care

O. HOSPICE SERVICES

Precertification: Required for inpatient admissions not related to hospice services. Not required for inpatient hospice admissions. If you fail to obtain required precertification, you will be responsible for a precertification penalty, or inpatient services will not be covered, depending on the type of admission.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: "Hospice services" are an alternative multi-disciplinary approach to medical care for the terminally ill. No curative or aggressive treatments are used.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description: When a member elects to use the hospice benefit, it is in lieu of other medical benefits available under this plan, except for care unrelated to the terminal illness or related complications.

The hospice agency determines the required level of care, which is subject to the medical necessity provisions of this benefit plan. Once the member selects the hospice benefit, the hospice agency coordinates all of the member's health care needs related to the terminal illness.

The member's physician must certify that the member is in the later stages of a terminal illness and prescribe hospice care, which must be provided by a state-licensed hospice agency. The member must meet the requirements of the hospice.

Benefits are available for the following services:

- ***Continuous Home Care:*** 24-hour skilled care provided by an R.N. or L.P.N. during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- ***Inpatient Acute Care:*** Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- ***Respite Care:*** Admission of the member to an approved facility to provide rest to the member's family or primary caregiver
- ***Routine Care:*** Intermittent visits provided by a member of the hospice team

P. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

Precertification: Required for non-emergency admissions. If you fail to obtain precertification for a non-emergency admission, you will be responsible for a precertification penalty.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: "Detoxification services" mean the initial medical treatment and support provided to a chemically dependent or addicted individual during acute withdrawal from a drug or substance.

Benefit Description: Benefits are available for medical observation and detoxification services needed to stabilize a member who has developed substance intoxication due to the ingestion, inhalation or exposure to one or more substances.

Benefit Maximum: Inpatient facility services are limited to a combined total maximum of thirty (30) days per member, per calendar year. Both in- and out-of-network admissions count toward the thirthy (30) day limit.

Q. INPATIENT HOSPITAL

Precertification: Required prior to all elective or scheduled inpatient admissions. If you fail to obtain precertification for elective or scheduled inpatient admissions, you will be responsible for a precertification penalty.

Your Cost-Share: You pay applicable deductible and coinsurance for all inpatient admissions. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

You pay in-network deductible and coinsurance for professional services provided by in- and out-of-network anesthesiologists, pathologists and radiologists.

Your cost-share is waived for facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including radiology and laboratory services
- General, spinal and caudal anesthetic provided in connection with a covered service
- Intensive care units and other special care units
- Medications, biologicals and solutions
- Operating, recovery and treatment rooms and equipment for covered services
- Radiation therapy or chemotherapy, except in conjunction with a noncovered transplant
- Room and board in a semi-private room, unless the hospital only has private rooms. If the hospital only has private rooms, only standard private rooms are covered (not deluxe).

Benefit-Specific Exclusion: Medications dispensed at the time of discharge from a hospital.

R. INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR)

Precertification: Required. If you fail to obtain precertification for an EAR admission, the services will not be covered.

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive EAR services at a noncontracted provider, you also pay the balance bill, in addition to applicable deductible and coinsurance.

After 60 days of care, you pay all charges for EAR services for the remainder of the calendar year.

Benefit Maximum: Combined in- and out-of-network maximum of 60 days of EAR services per member, per calendar year.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description: Benefits are available for an intense therapy program provided in a facility licensed to provide extended active rehabilitation. This care must be for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care

- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

S. LONG-TERM ACUTE CARE (INPATIENT)

Precertification: Required. If you fail to obtain precertification for a long-term acute care admission, those services will not be covered.

Your Cost-Share:

First 365 Days of Services: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status.

After 365 Days of Services: You pay applicable deductible and 50 percent coinsurance (at both in- and out-of-network providers).

If you receive services from a noncontracted provider, you also pay the balance bill.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description: Benefits are available for specialized acute, medically complex care for patients who require extended hospitalization and treatment in a facility that is licensed to provide long term acute care and which offers specialized treatment programs and aggressive clinical and therapeutic interventions.

Benefit-Specific Exclusions:

- Custodial Care
- Private Duty Nursing
- Respite Care

T. MATERNITY

Precertification: Not required.

Your Cost-Share:

Inpatient Services: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Outpatient Services:

In-Network: You pay a physician visit copay only for your first prenatal office or home visit. You pay a physician visit copay for any maternity services not included in the delivering provider's Global Charge and provided by a physician during an office or home visit. You pay in-network deductible and coinsurance for other covered maternity services.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided in the member's home must be rendered by an eligible provider. Your cost-share will vary depending on the type of provider and the provider's network status.

Applicable cost-share is waived for maternity services covered under the "*Preventive Services"* benefit and delivered by an in-network provider. If you receive these services from

an out-of-network provider, the services will be covered through your maternity benefit and you will pay the out-of-network cost-share. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share obligations may be affected by the addition of a newborn or adopted child, as described in the **Plan Administration** section of this book. If you have coverage only for yourself and no Dependents, addition of a child will result in a change from individual coverage to family coverage. If you currently have a per person deductible and out-of-pocket maximum, when a child is added to your plan, you will also be required to meet a family deductible and out-of-pocket maximum, and you may be required to pay additional premium.

Benefit-Specific Definition:

Global Charge: A fee charged by the delivering provider that may include certain prenatal, delivery and postnatal services.

Benefit Description:

Maternity benefits are available for covered services related to pregnancy. This includes certain screening tests such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases and others as determined by BCBSAZ. Certain tests, including some genetic screening, may not be covered. For a complete listing of covered prenatal screening, please call BCBSAZ Customer Service at the numbers listed in the front of this benefit book.

Maternity benefits are available for the expense incurred by a birth mother (who is not a member) for the birth of any child legally adopted by a member, if all of the following requirements are met:

- The member adopts the child within one year of birth;
- The member is legally obligated to pay the costs of birth; **and**
- The member has provided notice to BCBSAZ within sixty (60) days of the member's acceptability to adopt children.

This adopted child maternity benefit is secondary to any other coverage available to the birth mother. Contact Membership Services at the number listed in the front of this book to receive a BCBSAZ adoption packet.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

U. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Precertification: Not required.

Your Cost-Share: You pay applicable deductible and 50 percent of the Cost of Medical Foods.

Benefit-Specific Definitions:

"Cost" is defined as either billed charges, if the member buys the Medical Foods from an out-of-network provider or the allowed amount, if the member buys the Medical Foods from an in-network provider.

"Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry that meets all of the following requirements:

- The disorder is one of the diseases tested under the newborn screening program required under Arizona law (A.R.S. § 36-694);
- The disorder is such that an afflicted individual will need to consume Medical Foods throughout life in order to avoid serious mental or physical impairment; **and**
- The disorder must involve amino acid, carbohydrate or fat metabolism and have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues, as determined by BCBSAZ.

"Medical Foods" mean modified low protein foods and metabolic formulas that are all of the following:

- Administered for the medical and nutritional management of a member who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation;
- Essential to the member's optimal growth, health and metabolic homeostasis;
- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an M.D. or D.O. physician or a registered nurse practitioner;
- Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs (metabolic formula only); **and**
- Processed or formulated to contain less than one gram of protein per unit of serving (modified low protein foods only).

Benefit Description: Benefits are available for Medical Foods to treat Inherited Metabolic Disorders.

Benefit-Specific Exclusions:

- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available for purchase without a prescription or order from an M.D. or D.O. physician or registered nurse practitioner
- Foods and formulas that do not require supervision by an M.D. or D.O. physician or a registered nurse practitioner
- Food thickeners, baby food or other regular grocery products
- Medical foods and formulas for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
- Nutrition for a diagnosis of anorexia
- Nutrition for nausea associated with mood disorder, end stage disease etc.
- Spices and flavorings
- Standard oral infant formula

Claim submission for Medical Foods

You may buy Medical Foods from any source. If you buy Medical Foods from an out-of-network provider, you must submit a claim form with the following information:

- Member's diagnosis for which the Medical Foods were prescribed or ordered;
- Member's name, identification number, group number and birth date;
- Prescribing or ordering physician or registered nurse practitioner;
- The amount paid for the Medical Foods;
- The dated receipt or other proof of purchase; **and**
- The name, telephone number and address of the Medical Food supplier.

Medical Foods claim forms are available from BCBSAZ. Submit the completed Medical Foods Claim Form and the dated receipt to the address for claims submission at the front of this book.

Medical Foods also may be covered under the *"Home Health Services"* benefit.

V. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Precertification: Not required.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Services are available for the evaluation of decreased mental function or developmental delay.

W. OUTPATIENT SERVICES

Precertification: Not required.

Your Cost-Share: Outpatient services are often available in multiple settings, and generally result in separate charges for professional and facility services. Your cost-share will vary depending on the type of outpatient service, the location of the service, and the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

You pay in-network deductible and coinsurance for services provided by in- or out-of-network anesthesiologists, pathologists and radiologists.

Your cost-share is waived for facility charges from in-network providers for FDA-approved sterilization procedures provided to female members when the purpose of the procedure is contraception, as documented by your provider on the claim.

Diagnostic Laboratory services

- ***In-Network Physician's Office:*** You pay in-network deductible and coinsurance (cost-share is waived if you receive only covered laboratory services during your visit).
- ***In-Network Clinical Laboratory:*** Your cost-share is waived.
- ***In-Network Hospital Outpatient Laboratory Department:*** You pay in-network deductible and coinsurance.
- ***Out-of-Network Physician's Office, Clinical Laboratory or Hospital Outpatient Laboratory Department:*** You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Radiology services

- ***In-Network Physician's Office:*** You pay in-network deductible and coinsurance (copay is waived if you receive only covered radiology services during your visit).
- ***In-Network Hospital Radiology Department and Free-Standing Radiology Facility:*** You pay in-network deductible and coinsurance.
- ***Out-of-Network Physician's Office, Free-Standing Radiology Facility or Hospital Radiology Department:*** You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for the following outpatient services:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including laboratory and radiology services
- Outpatient surgery, which is defined as operative procedures and other invasive procedures such as epidural injections for pain management and various scope procedures, such as arthroscopies and colonoscopies
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant

X. PHARMACY BENEFIT

This benefit plan does not provide a pharmacy benefit. Contact your group benefit administrator for information.

Y. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST) AND RESPIRATORY THERAPY (RT) SERVICES

Precertification: Not required.

Your Cost-Share: You pay one (1) copay per member, per provider, per day for services, including evaluations, received from in-network providers. You pay out-of-network deductible and coinsurance for services received from out-of-network providers. For services received at outpatient facilities, you pay applicable deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for PT, OT, ST, and RT.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care meant to help an individual in the activities of daily living or for comfort and convenience
- Cognitive therapy
- Computer speech training and therapy programs and devices
- Custodial Care
- Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines
- Phase III cardiac rehabilitation programs
- Physical or occupational therapeutic services performed in a group setting of 2 or more individuals
- Rehabilitation services rendered after a member has met functional goals
- Rehabilitation services rendered when no objectively measurable improvement is reasonably anticipated
- Rehabilitation services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Strength training, cardiovascular endurance training, fitness programs, strengthening programs and other services designed primarily to improve or increase strength

Z. PHYSICIAN SERVICES

Precertification: Not required.

Your Cost-Share:

In-Network: You pay one copay, per member, per provider, per day for office, home and walk-in clinic visits. If you receive preventive services during one of these visits, your copay may be waived, as described in the *"Preventive Services"* section of this benefit book.

Your copay will be waived if you receive only the following services and no other covered service during your visit:

- Covered allergy injections
- Covered immunizations
- Covered laboratory services
- Covered physical therapy, speech therapy, occupational therapy (PT, OT, ST); these services are subject to in-network deductible and coinsurance

You pay in-network deductible and coinsurance for non-preventive physician services provided in locations other than an office, home or walk-in clinic, including but not limited to, inpatient and outpatient facilities. If you receive preventive physician services that are billed separately from inpatient or outpatient facility charges, your cost-share for those services may be waived as described in the *"Preventive Services"* section of this benefit book.

Out-of-Network: You pay out-of-network deductible and coinsurance for services rendered by an out-of-network physician. If you receive services from a noncontracted provider, you also pay the balance bill.

See the “Emergency” section for cost-share for emergency professional services.

You pay in-network deductible and coinsurance for services provided by in- or out-of-network anesthesiologists, pathologists and radiologists.

Benefit Description: Benefits are available for the following:

- General surgical procedures (including assistance at surgery) provided outside a physician’s office. Only certain surgical assistants are eligible providers. Call BCBSAZ Customer Service at the numbers listed in the front of this book to verify that the surgical assistant chosen by your physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your physician are in-network providers.
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics)
- Inpatient medical visits
- Second surgical opinions
- FDA-approved patches, rings and contraceptive injections for female members
- FDA-approved diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides for female members
- FDA-approved emergency contraception
- Professional physician services for FDA-approved sterilization procedures
- Professional physician services for fitting, implantation and/or removal (including follow-up care) of FDA-approved contraceptive devices in female members
- FDA-approved implanted contraceptive devices for female members

The following circumstances may impact member cost-share for physician services:

- If multiple surgical procedures are performed during a single operative session, the secondary procedures are usually reimbursed at reduced amounts. Noncontracted providers may bill the full amount for secondary, incidental or mutually exclusive procedures, in addition to the primary surgical procedure.

- You may receive services in a physician’s office that incorporate services or supplies from a provider other than your physician. If the other provider submits a separate claim for those services or supplies, you will pay the cost-share for the other provider plus the cost-share for your office visit. Examples of services or supplies from another provider include durable medical equipment from a medical supply company, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

Benefit-Specific Exclusion: All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.

AA. POST-MASTECTOMY SERVICES

Precertification: Required for inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification penalty.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider’s network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available, to the extent required by applicable state and federal law, for breast reconstruction following a medically necessary mastectomy. Benefits include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance, including postoperative implanted or external prostheses; and treatment of physical complications for all stages of the mastectomy, including lymphedema.

Notice of Rights Under the Women’s Health and Cancer Rights Act of 1998 (WHCRA): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving the mastectomy-related benefits described above under “Benefit Description,” coverage will be provided in a manner determined in consultation between the attending physician and the member being treated. These benefits are subject to the same cost-share generally

applicable to other medical and surgical benefits provided under this plan, as described in the "Member Cost-share" section of your SBC. If you would like more information on WHCRA benefits, call BCBSAZ Customer Service at the number listed in the front of this benefit book.

BB. PREGNANCY, TERMINATION

Precertification: Required for inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification penalty.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for abortions that meet the following requirements:

The treating provider certifies in writing the abortion is medically necessary in order to save the life of the mother or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.

Benefits are also available for abortifacient medications for the abortions covered under this plan, including some oral medications as described in the BCBSAZ Medical Coverage Guidelines.

Benefit-Specific Exclusion: Abortions, except as stated in this benefit.

CC. PRESCRIPTION MEDICATIONS FOR THE TREATMENT OF CANCER

This benefit plan does not provide prescription medications for the treatment of cancer benefits. Contact your group benefit administrator for information.

DD. PREVENTIVE SERVICES

Precertification: Not required.

Your Cost-Share:

All preventive services, except for mammography and nutritional counseling and training must be received from in-network providers or the services will not be covered.

Your cost-share is waived, regardless of the location where services are provided, if:

- You receive services from an in-network provider;
- You receive one of the services listed in the Benefit Description subsection of this Preventive Services section; **and**
- The diagnosis codes, procedure codes, or combination of procedure and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive.

Out-of-Network Mammography Services: Deductible is waived. You pay out-of-network coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: "Preventive Services" are those services performed for screening purposes when you do not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition, which is determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.

Benefit Maximums: Benefits are limited to one (1) manual or electric (not hospital grade) breast pump and breast pump supplies per female member, per calendar year.

Benefit Description: All preventive services listed in this benefit section, except for certain services cross-referenced in other benefit sections, must be received from in-network providers or the services will not be covered. For services listed in this benefit section and cross-referenced in other benefit sections, see the cross-referenced benefit section to determine whether services from out-of-network providers are covered and, if applicable, cost-share for those services from out-of-network providers.

Benefits are available for the following services, as appropriate for the member's age and gender and as recommended by your provider:

- Preventive physical examination, i.e. routine physical examination, including the following services when done for screening purposes only:

    - resting electrocardiogram (EKG)
    - lung function test (spirometry)
    - vision and hearing screening (this may include newborn audiological evaluation in the hospital)
    - fecal occult blood test
    - general health laboratory panel (bilirubin, calcium, carbon dioxide, chloride, creatinine, alkaline phosphatase, potassium, total protein, sodium, ALT, SGPT, AST, SGOT, BUN, TSH)
    - thyroid function testing (TSH)
    - complete blood count (CBC)
    - lipid panel (cholesterol panel and triglycerides)
    - fasting glucose (blood sugar)
    - urinalysis
    - blood lead
    - sexually transmitted disease (STD) testing
    - prostate specific antigen (PSA) testing
    - TB testing

- Aspirin prescribed for prevention of cardiovascular disease for men ages 45 to 79 and women ages 55 to 79.
- Behavioral intervention to promote breast-feeding for women
- Bone density testing for osteoporosis
- Counseling and behavioral interventions to promote sustained weight loss for obese adults
- Counseling (annually) for HIV infection for all sexually active women
- Counseling (annually) on sexually transmitted infections for all sexually active women
- Counseling for members ages 10-24 regarding minimizing the risk of UV radiation exposure to reduce the risk of skin cancer
- Counseling for tobacco cessation and augmented pregnancy counseling for members who use tobacco
- Counseling on contraceptive methods for all women with reproductive capacity
- FDA-approved contraceptive methods for female members, as prescribed. See the "Family Planning" and "Physician Services" sections.
- FDA-approved sterilization procedures for female members, as prescribed. See the "Family Planning" and "Physician Services" benefit sections.
- Folic acid supplementation prescribed for females.
- Lactation support counseling during pregnancy and/or in the post-partum period
- Mammogram
- Oral fluoride supplementation prescribed for children ages 6 months through 5 years who live in areas where the water service is deficient in fluoride
- Physical therapy or exercise for members age 65 and older living in community dwellings to minimize falls
- Rental or purchase of manual or electric breast pumps and breast pump supplies when obtained from in-network durable medical equipment (DME) providers. See the "Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics" benefit section.
- Repeated antibody testing for unsensitized Rh(D)-negative pregnant women at 24-28 weeks gestation, unless the biological father is known to be Rh(D) negative
- Routine gynecologic exam including Pap test and other cervical cancer screening test
- Routine immunizations and immunizations for foreign travel, as determined by BCBSAZ
- Routine iron supplementation prescribed for asymptomatic children ages 6 months through 12 months who are at increased risk for iron deficiency anemia
- Screening and counseling (annually) for interpersonal and domestic violence
- Screening, counseling and intervention for obesity
- Screening for abdominal aortic aneurysm for men ages 65 to 75 who have ever smoked
- Screening for alcohol misuse and behavioral counseling interventions for pregnant women
- Screening for asymptomatic bacteriuria for pregnant women at 12-16 weeks gestation or at first prenatal visit, if later
- Screening for depression for members age 18 and older

- Screening for gestational diabetes in pregnant women between 24 and 28 weeks gestation and at first prenatal visit
- Screening for Hepatitis B virus infection for pregnant women at their first prenatal visit
- Screening for iron deficiency anemia for asymptomatic pregnant women
- Screening for major depressive disorders for members ages 12 through 18
- Screenings for newborns as required by Arizona and federal law
- Screening for Rh(D) incompatibility through blood typing and antibody testing for pregnant women at their first prenatal visit
- Screening sigmoidoscopy or colonoscopy
- Smoking cessation devices, as prescribed
- Vision screenings for children under age 5
- Vitamin supplementation for members age 65 and older living in community dwellings to minimize falls

For information on the foreign travel immunizations covered under this benefit, go to the Medical Coverage Guidelines available at www.azblue.com/member, or call BCBSAZ Customer Service at the number listed in the front of this book.

Benefit-Specific Exclusions:

- Abortifascient medications
- All over-the-counter contraceptive methods and devices for male members, including but not limited to, male condoms.
- Any service or test not specifically listed in this benefit description or in another section of this benefit book, such as chest X-rays, will not be covered when performed for preventive or screening purposes
- Except as stated in this benefit book, preventive services provided by an out-of-network provider.

Services or tests listed under this benefit and provided to a member with a specific diagnosis, signs or symptoms of a condition or disease for which the test is being performed may be covered through another benefit section of this plan. Certain maternity services covered under this benefit are also available through the "Maternity" benefit.

EE. RECONSTRUCTIVE SURGERY AND SERVICES

Precertification: Required for inpatient admissions. If you fail to obtain precertification, you will be responsible for a precertification penalty.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for reconstructive surgery, which is surgery performed to improve or restore the impaired function of a body part or organ resulting from one of the following:

- Congenital defects;
- Illness and disease;
- Injury and trauma;
- Surgery; **or**
- Therapeutic intervention

Benefit-Specific Exclusion: Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy to the extent required by state and federal law.

FF. SKILLED NURSING FACILITY (SNF)

Precertification: Required. If you fail to obtain precertification for a SNF admission, the services will not be covered.

Your Cost-Share: You pay in-network deductible and coinsurance.

After 90 days of care, you pay all charges for skilled nursing facility services for the remainder of the calendar year.

Benefit Maximum: 90 days of SNF services per member, per calendar year.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, rehabilitation, skilled nursing and hospice). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description: Benefits are available for inpatient skilled nursing facility services provided in a facility licensed to offer skilled nursing services. Skilled nursing services must be provided by and under the supervision of qualified and licensed professionals, such as a licensed practical nurse (L.P.N.) or registered nurse (R.N.) and provided at a level of complexity and sophistication requiring assessment, observation, monitoring and/or teaching or training to achieve the medically desired outcome**.**

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ
- SNF services received from out-of-network providers

GG. SPECIALTY MEDICATIONS

This benefit plan does not provide a specialty medications benefit. Contact your group benefit administrator for information.

HH. TRANSPLANTS - ORGAN - TISSUE - BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES

Precertification: Required prior to any organ, tissue or bone marrow transplant or stem cell procedure. If you fail to obtain precertification, the services will not be covered.

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

If both a donor and a transplant recipient are covered by a BCBSAZ plan or a plan administered by BCBSAZ, the transplant recipient pays the cost-share related to the transplant.

BCBSAZ is contracted with certain facilities to provide covered transplants to BCBSAZ members. Not all such facilities are contracted to provide services related to a covered transplant, such as pre-transplant testing, certain types of chemotherapy and radiation therapy and other services covered under this plan. If you receive pre-transplant testing or other services associated with the transplant from a facility that is not contracted with BCBSAZ or a Host Blue to provide those services, you will pay your out-of-network cost-share, plus the balance bill.

Benefit-Specific Definition: "Bone Marrow Transplant" is a medical or surgical procedure comprised of several stages, including:

- Administration of high dose chemotherapy and high dose radiotherapy as prescribed by the treating physician;
- Harvesting of stem cells from the bone marrow or the blood of a third-party donor (allogeneic transplant) or the member (autologous transplant) and all component parts of the procedure;

- Hospitalization and management of reasonably anticipated complications;
- Infusion of the harvested stem cells; **and**
- Processing and storage of the stem cells after harvesting.

Benefit Description: The following transplants are eligible for coverage if they meet the Medical Coverage Guidelines:

- Allogeneic and autologous bone marrow or stem cell
- Autologous islet cell transplantation (AICT)
- Cornea
- Heart; heart-lung; lung (lobar, single and double lung); kidney; pancreas; kidney-pancreas; liver; small bowel; small bowel-multivisceral

Benefits are available for the following services in connection with, or in preparation for, a covered transplant:

- Inpatient and outpatient facility and professional services
- Air and ground transportation of a medical team to and from the site in the contiguous states of the United States to obtain tissue that is subsequently transplanted into a member
- Bone marrow search and procurement of a suitable bone marrow donor when a member is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
- Chemotherapy or radiation therapy associated with transplant procedures
- Harvest and reinfusion of stem cells or bone marrow
- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ. Covered donor expenses include complications and follow-up care related to the donation for up to six (6) months post-transplant, as long as the recipient's coverage with or administered by BCBSAZ remains in effect
- Pre-transplant testing and services

Benefit-Specific Exclusions:

- Expenses related to a noncovered transplant
- Expenses related to donation of an organ to a recipient who is not covered by BCBSAZ
- Transplants that do not meet the Medical Coverage Guidelines

II. TRANSPLANT TRAVEL AND LODGING

Precertification: Not required.

Your Cost-Share: Not applicable.

Benefit Maximum: Maximum of $10,000 per member, per transplant. Covered expenses incurred by a caregiver accumulate toward the member's $10,000 per transplant maximum.

Benefit-Specific Definition: "Caregiver" is the individual primarily responsible for providing daily care, basic assistance and support to a member who is eligible for transport lodging and reimbursement. Caregivers may perform a wide variety of tasks to assist the member in his or her daily life, such as preparing meals, assisting with doctors' appointments, giving medications or assisting with personal care and emotional needs.

Benefit Description: Coverage is available for reimbursement of the travel and lodging expenses listed below, when all the following criteria are met:

- The expenses are incurred by a member receiving a covered transplant procedure, the donor or the member's Caregiver;
- BCBSAZ has precertified the transplant procedure;
- The distance from the member's, donor's or Caregiver's residence must be more than seventy-five (75) miles from the transplant facility;
- The member is receiving a covered solid organ, bone marrow or stem cell transplant;
- The member must receive the transplant from a provider contracted with BCBSAZ, a provider contracted with the local Blue Cross and/or Blue Shield plan where services are rendered or a Blue Distinction Centers for Transplants (BDCT) facility;

- The member must be receiving medically necessary pre- and post-operative treatments, including without limitation, treatment of complications related to the covered transplant or routine follow-up care for a covered transplant or a transplant that occurred while the member was covered by another insurance plan; **and**
- The expenses are for any of the following:

    - Meal expenses;
    - Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; bus; train or air fare; **and**
    - Room charges from hotels, motels and hostels or apartment rental.

Benefit-Specific Exclusions:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or Internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of the $10,000 per member, per transplant maximum
- Ambulance transportation (ground or air)
- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with noncovered transplant services or any follow-up care, including treatment of complications
- Expenses for travel or lodging related to evaluation, consultation or medical testing to determine if a member is a candidate for transplantation
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Travel and lodging expenses for transplants other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service
- Travel and lodging expenses for members, donors or Caregivers when the member, donor or Caregiver does not travel more than seventy-five (75) miles for an authorized transplant or transplant-related services
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement

To request reimbursement of eligible transplant travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to BCBSAZ. The address for claims submission and phone number for requesting claim forms are listed in the BCBSAZ Customer Service section at the front of this book.

JJ. URGENT CARE

Precertification: Not required.

Your Cost-Share: You pay one urgent care copay per member, per provider, per day for services from a provider who is contracted with BCBSAZ to render urgent care services. You pay applicable cost-share if you receive urgent care services from an in-network provider who is not specifically contracted for urgent care services. You pay out-of-network deductible and coinsurance if you receive services from an out-of-network urgent care provider. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: “Urgent care” means treatment for conditions that require prompt medical attention, but which are not emergencies.

Benefit Description: Benefits are available for urgent care services rendered by a contracted, free-standing urgent care provider. These providers are listed in your provider directory and on the BCBSAZ website at www.azblue.comunder “Urgent Care Centers.”

Please be aware that the BCBSAZ network includes some providers, such as hospitals, that offer urgent care services, but which are not specifically contracted with BCBSAZ as urgent care providers. No matter what the circumstances, if you obtain urgent care services at a hospital or a hospital’s on-site urgent care department, you will be responsible for the applicable emergency room cost-share.

KK. VISION EXAMS (ROUTINE)

This benefit plan does not provide a routine vision exam benefit, except vision screenings for children under age 5 are covered under the Preventive Services section. Contact your group benefit administrator for information.

WHAT IS NOT COVERED

NOTWITHSTANDING ANY OTHER PROVISION IN THIS PLAN, NO BENEFITS WILL BE PAID FOR EXPENSES ASSOCIATED WITH THE FOLLOWING:

Abortions, except as stated in this plan

Activity Therapy – Activity therapy and milieu therapy, including community immersion, integration, home independence and work re-entry therapy; and any care intended to assist an individual in the activities of daily living; and any care for comfort and convenience, except for limited hospice benefits

Acupuncture

Alternative Medicine – Non-traditional and alternative medical therapies; interventions; services and procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; aromatherapy

Bariatric Surgeries excluded by the BCBSAZ Medical Coverage Guidelines

Benefit-specific exclusions and limitations listed in this book under particular benefit sections

Biofeedback and hypnotherapy

Blood Administration for the purpose of general improvement in physical condition

Body Art, Piercing and Tattooing – Services related to body piercing, cosmetic implants, body art, tattooing and any related complications

Care required by state or federal law to be supplied by a public school system or school district

Certain Types of Facility Charges – Inpatient and outpatient facility charges for treatment provided by the following facilities are not covered: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes. Inpatient and outpatient facility charges for services provided by residential treatment facilities are not covered except for certain very limited situations based upon BCBSAZ medical necessity criteria. All other inpatient and outpatient services provided by residential treatment facilities are not covered.

Charges associated with the preparation, copying or production of health records

Cognitive and Vocational Therapy – Services related to improving cognitive functioning (i.e., higher brain functions), reinforcing or re-establishing previously learned thought processes, compensatory training, sensory integrative activities and services related to employability

Complications of Noncovered Services – Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under this plan. Medical complications arising from an abortion are covered under this plan

Computer Speech Training, Therapy Programs and Devices

Consumable Medical Supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as stated in this plan

Cosmetic Services and any Related Complications – Surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy or to medically necessary surgery to improve or restore the impaired function of a body part or organ.

Cosmetics and health and beauty aids

Counseling – Counseling and behavioral modification services, except as stated in this plan

Court-Ordered Services – Court-ordered testing, treatment and therapy, unless such services are otherwise covered under this plan as determined by BCBSAZ

Custodial Care

Dental – Except as stated in this plan, dental and orthodontic services; placement or replacement of crowns, bridges or implants; any fixed dental reconstruction of the teeth; orthodontics; extractions of teeth; dentures; vestibuloplasty and surgical orthodontics; and any procedures associated with the services listed in this exclusion, including but not limited to procedures associated with dental implants and fitting of dentures

Dietary and Nutritional Supplements – All dietary, caloric and nutritional supplements, such as specialized formulas for infants, children or adults or other special foods or diets, even if prescribed, except as stated in this plan

Expenses for services that exceed benefit limitations

Experimental or Investigational Services

Fees- Associated with the collection or donation of blood or blood products

Fees – Fees other than for medically appropriate, in-person, direct member services, except as stated in this plan

Fees – Fees for concierge medicine services

Fertility and Infertility Services – Services to improve or achieve fertility (ability to conceive) or to diagnose and treat infertility (inability to conceive)

Flat Feet – Services for treatment of flat feet, weak feet and fallen arches, except arch supports may be covered when medically necessary for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

Foot Care – Services for foot care, including trimming of nails or treatment of corns or calluses, except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

Free Services – Services you receive at no charge or for which you have no legal obligation to pay

Genetic and Chromosomal Testing, Screening and Therapy – Genetic and chromosomal testing, screening and therapy for an individual who is asymptomatic, unaffected or not displaying signs or symptoms of a disorder for which the test, screening or therapy is performed

Government Services – Services provided at no charge to the member through a governmental program or facility

Growth Hormone – Growth hormone, except as specified in the Medical Coverage Guidelines. Growth hormone to treat Idiopathic Short Stature (ISS) is expressly excluded.

Hearing Services and Devices, except as stated in this plan

Inpatient or Outpatient Long Term Care

Lifestyle Education and Management Services

Lodging and Meals – Lodging and meals, except as stated in this plan

Maintenance Services – Services rendered after a member has met functional goals; services rendered when no objectively measurable improvement is reasonably anticipated, services to prevent regression to a lower level of function, services to prevent future injury and services to improve or maintain posture, except as stated in this plan

Manipulation under anesthesia, except for reductions of fractures and/or dislocations done under anesthesia

Marijuana – Medical marijuana, marijuana and any costs or fees associated with obtaining medical marijuana, such as obtaining an initial or renewal registry identification card, even when prescribed and obtained in compliance with state law(s)

Massage Therapy – Massage therapy, except in limited circumstances as described in the Medical Coverage Guidelines

Medical equipment, supplies, and medications sold on or through unregulated distribution channels as determined by BCBSAZ, including online sources such as eBay, Craig's List or Amazon.com; or at garage sales, swap meets, and flea markets

Medications – Medications which are:

- Not FDA approved
- Not required by the FDA to be obtained with a prescription, except as stated in this plan
- Not used in accordance with the Medical Coverage Guidelines
- Used to treat a condition not covered by BCBSAZ
- Off-label, unlabeled and orphan medications, except as stated in this plan

Medications Dispensed in Certain Settings – Prescription medications given to the member, for the member's future use, by any person or entity that is not a licensed pharmacy, home health agency, specialty pharmacy or hospital emergency room

Membership Costs or Fees associated with health clubs and weight loss programs.

Neurofeedback

Non-Medically Necessary Services – Services that are not medically necessary as determined by BCBSAZ or BCBSAZ's contracted vendor. BCBSAZ and/or the contracted vendor may not be able to determine medical necessity until after services are rendered

Non-Medical Ancillary Services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy

Over-the-Counter Items – Medications, devices, equipment and supplies that are lawfully obtainable without a prescription, except as stated in this plan

Payments for exclusions imposed by any certification requirement

Personal Comfort Services – Services intended primarily for assistance in daily living, socialization, personal comfort and convenience, homemaker services and services primarily for rest, domiciliary or convalescent care, costs for television, telephone, newborn infant photographs, meals other than meals provided to a member by an inpatient facility while the member is a patient in the inpatient facility, birth announcements, and other services and items for other non-medical reasons

Phase 3 Cardiac Rehabilitation

Prescription Medications For The Treatment Of Cancer

Prescription Medications Obtained From A Retail Or Mail Order Pharmacy

Private Duty Nursing

Refills or Replacements - Refills or replacements for medications covered under this benefit plan that are lost, stolen, spilled, spoiled or damaged

Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic, or custodial evaluations.

Reproductive Services---Procedures, treatment, office visits, consultations and other services related to the genetic selection and/or preparation of embryos and implantation services including, but not limited to, pre-implantation genetic diagnosis and in vitro fertilization and related services

Respite Care, except as covered in the Hospice Services benefit

Reversal of Sterilization

Screening Tests – Any testing performed on an individual who does not have a specific diagnosis or acute signs or symptoms of a condition or disease for which the test is being performed, regardless of whether the individual has a family history or other risk factors for the disease or condition, except as stated in this plan

Sensory Integration, LOVAAS Therapy and Music Therapy

Services for Children of a Dependent, unless the child is also eligible as a Dependent.

Services for Idiopathic Environmental Intolerance – Services associated with environmental intolerance from unknown causes (idiopathic), multiple chemical sensitivity, the diagnosis or treatment of environmental illness (clinical ecology), such as chemical sensitivity or toxicity from exposure to atmospheric or environmental contaminants, pesticides or herbicides

Services for Weight Loss and Gain, except as stated in this plan

Services from a Family Member – Services delivered by an eligible provider who is a member of your immediate family or a member of a Dependent's immediate family. "Immediate family" members are: parents, siblings, children, stepparents, stepchildren, spouses, domestic partners, grandparents, grandchildren and any of the preceding individuals related to the member by marriage. When a provider is also the covered person, services rendered by that provider for himself or herself are also excluded from coverage

Services from Ineligible Providers

Services For Conditions Medicare Identifies as Hospital-Acquired Conditions (HACs), and/or National Quality Forum (NQF) "Never Events"

Services Paid for By Other Organizations – Services customarily paid for by an employer, such as worksite or ergonomic evaluations; the government; a school; biotechnical, pharmaceutical or medical device industry sources; or other individuals and organizations

Services Prior to Member's Coverage Effective Date

Services Provided After the Member's Coverage Termination Date, except as stated in this plan

Services Related to or Associated with Noncovered Services

Services Without A Prescription – Services and supplies that are required by this plan to have a prescription and are not prescribed by a physician or other provider licensed to prescribe

Sexual Dysfunction – Services for sexual dysfunction, regardless of the cause, and medications for the treatment of sexual dysfunction

Smoking Cessation – Smoking cessation programs, except as stated in this plan

Specialty Medications

Spinal Decompression or Vertebral Axial Decompression Therapy (VAX-D)

Strength Training – Services primarily designed to improve or increase fitness, strength or athletic performance, including strength training, cardiovascular endurance training, fitness programs and strengthening programs, except as stated in this plan

Telephonic and Electronic Consultations – Telephonic and electronic consultations, except as stated in this plan

Therapy Services, except as stated in this plan

Therapy to Improve General Physical Condition including, but not limited to, inpatient and outpatient routine long term care

Training and Education – Training and education, except as stated in this plan

Transportation – Transport services and travel expenses, except as stated in this plan

Vision – Routine vision exams, except for preventive vision exams for members under age 5; vision therapy; eye exercises; all types of refractive keratoplasties including but not limited to radial keratotomy and/or lasik surgery; any other procedures, treatments and devices for refractive correction; eyeglass frames and lenses, contact lenses and other eyewear; vision examinations for fitting of eyeglasses and contact lenses, except as stated in this plan

Vitamins – All vitamins, minerals and trace elements that are lawfully obtainable without a prescription, except as stated in this plan

Workers' Compensation – Illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election

PLAN ADMINISTRATION

Changes to Your Information

If you do not tell us about changes, correspondence from BCBSAZ may not reach you in a timely manner. Also, you may have to reimburse BCBSAZ for claims payments we make on behalf of you or your Dependents, if you or your Dependents became ineligible but incurred claims before you gave us notice. You may also have to pay costs incurred by BCBSAZ for collection of claims payments made after you or your Dependents became ineligible.

Notify BCBSAZ Membership Services about changes to the following:

- Individuals being added to the benefit plan: Spouse, newborns, adopted children, children placed for adoption, stepchildren
- Eligibility of you or your Dependents for Medicare during the term of this contract
- Your mailing address or phone number
- Other medical coverage that you or your Dependents add or lose, including any changes in benefits
- Eligibility of you or your Dependents for Arizona Health Care Cost Containment System (AHCCCS) or other Medicaid coverage during the term of this contract
- Eligibility of you or your Dependents for the Children's Health Insurance Program (CHIP) coverage during the term of this contract
- Eligibility of you or your Dependents for basic health plan (BHP) coverage during the term of this contract
- Eligibility of you or your Dependents for individual coverage purchased through a state or Federal Exchange.
- Individuals removed from the benefit plan due to divorce or death
- A disabled Dependent age 26 or older who is no longer disabled

Coordination of Benefits (COB)

If you are eligible for benefits under any other group health insurance, the combined benefit payments from all coverages will not exceed 100 percent of the billed charges. In addition, BCBSAZ's payment will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If your other group health insurance does not include a coordination of benefits provision, the other group coverage pays first. If your other group health insurance provides for coordination of benefits, the following rules will be used to determine which coverage will pay first:

- If the person is an inpatient on the day this benefit plan becomes effective and benefits are payable under the person's prior health care coverage for the inpatient stay, the prior health care coverage pays first.

- If the person who received care is covered as an active employee under one benefit plan and as a Dependent under another, the employee coverage pays first.

- If the person who receives care is covered as an active employee under one benefit plan and as an inactive employee under another, the coverage through active employment pays first.

- If the person who receives care is a Dependent child, then the plan benefits of the parent whose birthday occurred earlier in a calendar year shall cover the child first.

- If both parents have the same birthday, the benefits of the plan that covered a parent longer shall cover a Dependent child first.

- If one of the plans determines the order of benefits based upon the gender of a parent and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rule shall determine the order of benefits.

- If the Dependent child's parents are legally separated or divorced, the following applies:

    - If a court decree specifies the parent who is financially responsible for the child's healthcare expenses, the specified parent's coverage pays first.

    - If there is no applicable court decree, the custodial parent's coverage pays first. If the custodial parent has remarried, the stepparent's coverage pays second. The non-custodial parent's coverage pays last.

- If the parents have joint custody, the plan benefits of the parent whose birthday occurred earlier in a calendar year pays first.

When none of the above applies, the coverage you have had for the longest continuous period of time pays first (see *"Non-Duplication of Benefits"*).

Non-Duplication of Benefits

If services are covered under this benefit plan and one or more other group benefit plans that are issued or administered by BCBSAZ, the rules described above in *"Coordination of Benefits"* will be used to determine which coverage pays first. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If services are covered under this benefit plan and one or more BCBSAZ individual contracts, benefits will be paid first under the individual contract. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed 100 percent of the amount BCBSAZ would have paid if you had no other coverage. BCBSAZ does not coordinate benefits with non-group coverage provided by an insurance plan other than BCBSAZ.

Definitions Related to Plan Administration

- **"Dependents"** are the following individuals: (1) the Contractholder's spouse under a legally valid existing marriage; and (2) the Contractholder's children or the children of the Contractholder's spouse, including birth children, legally adopted children, stepchildren, children placed for adoption, children under legal guardianship substantiated by a court order and children who are entitled to coverage under a medical support order.

- **"Disabled Dependent Child"** is a child who has reached age 26 and who meets criteria for coverage under this plan described in "Eligibility Requirements," below.

- **"Employee"** refers to the person eligible for this benefit plan because of his/her employment relationship or affiliation to the Group. An employee is also the Contractholder under this plan.

- **"Group"** refers to the employer or other entity to which a Group Master Contract is issued by BCBSAZ.

- **"Group Master Contract"** refers to the agreement between the employer or other entity and BCBSAZ.

- **"Open Enrollment"** is an annual period during which the Contractholder and Dependents are eligible to enroll for coverage or change benefit plan options. Your Group's benefit plan administrator will notify the Contractholder of the Group's open enrollment period. Contractholders and/or any Dependents can change benefit plans only during an open enrollment period, except as set forth in this benefit book or as allowed under applicable law.

Eligibility Requirements

- **Contractholder** – A Contractholder becomes eligible to enroll for coverage after meeting the Group's eligibility requirements outlined in the Group Master Contract.

- **Children** – Children are eligible for Dependent coverage until their 26th birthday.

- **Disabled Dependent Child** – A child who has reached age 26 may continue coverage as a Dependent under this plan if the child is otherwise eligible for the plan and meets all of the following criteria:

  - Has been covered under this plan up to the day he or she is no longer eligible for coverage based on the age limit(s) specified in this plan;
  - Is continuously incapable of self-sustaining employment because of mental or physical disability on the date the Dependent reaches age 26; **and**
  - Is dependent on the Contractholder for maintenance and support, as determined by BCBSAZ criteria.

  Medical reports, acceptable to BCBSAZ, must substantiate the incapacity and must be submitted by the Contractholder within thirty-one (31) days of the date such child reaches age 26. The child's eligibility to continue this coverage as a Dependent under this plan is subject to periodic review by BCBSAZ.

BCBSAZ will determine whether your child meets disability criteria in its sole and absolute discretion and will provide a copy of the criteria used to make this decision upon request. A Contractholder has an affirmative obligation to inform BCBSAZ if the child's disability ceases. Cessation of the child's disability or dependency will terminate the child's coverage as a Dependent under this plan.

Effective Date of Coverage

- **Contractholder** – A Contractholder's effective date of coverage will be either the date the Contractholder becomes eligible to enroll or the first billing date after the Contractholder becomes eligible to enroll as determined by the Group, as long as the Contractholder completes the application process within thirty-one (31) days of becoming eligible.

- **Dependent –** Dependent coverage is available only if an eligible Contractholder has enrolled for coverage. Eligible Dependents will have the same effective date as the Contractholder if they are included on the application at the time the Contractholder first enrolls. If the Contractholder and/or Dependents do not enroll when first eligible, the Contractholder and/or Dependents may only apply for coverage at the Group's annual open enrollment period, except as stated in *"Special Enrollment Provisions"* or if court-ordered. The effective date of coverage for an application made during an open enrollment period is the Group's anniversary date following that open enrollment period.

- **Spouse –** The effective date for a new spouse is the date of marriage, if the Contractholder completes an application within thirty-one (31) days of that date; otherwise, the spouse may not enroll until the next open enrollment period, unless he or she qualifies under *"Special Enrollment Provisions."*

- **Newborn/Adopted Child/Child Placed for Adoption –** A child is eligible for coverage under this benefit plan following birth or adoption, so long as: (1) the parent or guardian covered under this benefit plan remains eligible for coverage; and (2) the parent or guardian covered under this benefit plan submits the appropriate enrollment documentation to the group to enroll the child for coverage within thirty-one (31) days following the date of birth, adoption or placement for adoption. No claims will be paid until the child is enrolled in this benefit plan and BCBSAZ receives an enrollment file from the group that indicates the child has been enrolled in this benefit plan. If the parent or guardian covered under this benefit plan does not enroll the child within thirty-one (31) days following the date of birth, adoption or placement for adoption, the parent or guardian covered under this benefit plan must wait until the next open enrollment period to enroll the child.

  Contact Membership Services at the number listed in the front of this benefit book to receive a BCBSAZ adoption packet.

- **Other Children** – The effective date for a Dependent child who is not a newborn child, adopted child or a child placed for adoption (as described above) shall be the date the child becomes an eligible Dependent, as long as the Contractholder completes an application to add the child within thirty-one (31) days of that date. If an application is not completed within thirty-one (31) days, the child may not enroll until the next open enrollment period, unless the child qualifies under *"Special Enrollment Provisions."*

Loss of Eligibility

Contractholder eligibility ends on the following days:

- The end of the month in which the Contractholder was entitled to receive compensation from the Group, regardless of the date such compensation is actually paid, and for which BCBSAZ has received premium.

- The end of the month in which an approved leave of absence expires, if the Contractholder fails to return to active employment.

- The date death occurs.

- The end of the month in which the Group and/or Contractholder fails to pay premium and any grace period available under Arizona law is exhausted.

Dependent eligibility ends on the following days:

- For a Dependent spouse and any children of that spouse who are not the birth or adopted children of the Contractholder, the end of the month in which the final divorce decree is effective.

- The end of the month in which a child turns age 26, if the child is not a disabled child.

- The end of the month in which the disability or dependency ceases for a disabled child over age 26.

- The end of the month in which a child covered by a medical support order is no longer eligible under the court order or administrative order.

- The end of the month in which the Contractholder's or any Dependent's death occurs.

Some Groups have up to thirty-one (31) days to notify BCBSAZ that a Contractholder or Dependent has become ineligible. Until BCBSAZ receives notice and processes the termination of eligibility, BCBSAZ may quote benefits, give precertification or pay claims that ultimately will be recouped from members or providers, if it is later determined the member was ineligible on the date services were received. Such benefit quotations or precertifications become null and void, regardless of whether the Group has notified the Contractholder that eligibility terminated.

Special Enrollment Periods

A special enrollment period is available for the following qualifying events, as applicable to the individual seeking coverage when such individual requests coverage under this benefit plan by completing an application within thirty-one (31) days of the loss of other coverage:

- A person loses minimum essential coverage, as that term is defined in applicable law
- A person gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption
- The death of the covered employee
- A person has coverage through his or her spouse and the spouse dies
- A person has coverage through his or her spouse and a divorce or legal separation occurs
- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of the covered employee's employment
- The divorce or legal separation of the covered employee from the covered employee's spouse
- The covered employee becomes entitled to Medicare
- A dependent child ceases to be a dependent child under the generally applicable requirement of the plan
- A proceeding in a case under title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time
- Exhaustion of a person's COBRA coverage;
- Termination of the employer's contribution toward coverage
- Termination of the covered employee's eligibility for coverage
- The covered employee's employer terminates coverage
- The covered employee is employed by an employer that offers multiple health benefit plans and the covered employee elects a different plan during open enrollment
- A person exhausts a lifetime maximum on all benefits under the other policy or plan (qualifying event is denial of claim due to operation of a lifetime maximum
- A person no longer lives, resides or works in the other plan's service area and no other benefit plan is available to that person; **and**

A special enrollment period is available for the following qualifying events, as applicable to the individual seeking coverage when such individual requests coverage under this benefit plan by completing an application within sixty (60) days of the loss of other coverage:

- A person loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- A person received notice that he or she is eligible for a Medicaid or CHIP premium assistance subsidy; **and**

Any other special enrollment rights available under applicable state or federal law

Termination of Coverage

Reasons for Termination

The Contractholder and/or any Dependents' coverage under this benefit plan may terminate for the following reasons, including but not limited to:

- The Contractholder and/or any Dependent(s) die

- The Contractholder and/or Dependent(s) request termination of coverage
- The Contractholder and/or Dependents obtain other coverage that qualifies as minimum essential coverage
- The Contractholder and/or Dependents are newly eligible for Medicaid, CHIP or the Basic Health Plan (BHP)
- Nonpayment of premiums by the Group and/or Contractholder, after expiration of any applicable grace period available under Arizona law
- Coverage for the Contractholder and/or Dependents is rescinded

Termination Date of Coverage

BCBSAZ will notify the Group and/or the Contractholder of any termination dates of coverage for the Contractholder and/or any Dependents. The Contractholder and/or Dependents' coverage ends no later than the date the Group Master Contract terminates. If the Contractholder's coverage terminates, coverage for all Dependents also terminates on same day.

Benefits After Termination

Except as described below, you have no coverage on and after the date coverage ends, regardless of the reason for termination. This applies even if the expense was incurred because of an accident, injury or illness that occurred or existed while this coverage was in effect.

Certificates of Creditable Coverage

When your coverage ends, BCBSAZ will send you a certificate that shows the period you were covered under this benefit plan. If you do not receive your certificate within thirty (30) days of your termination, you may request a certificate by contacting BCBSAZ Membership Services at any time up to twenty-four (24) months after your coverage ends.

Continuation of Coverage

Under federal law it is the Group's responsibility, as plan administrator, to inform employees and Dependents of the availability, terms and conditions of continuation of coverage available under COBRA.

COBRA requires most employers who have twenty or more employees and sponsor a group health plan to offer employees and their covered Dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Continuation of coverage is available when an employee is absent from employment by reason of service in the uniformed services, as defined by applicable federal law. You must check with your benefit plan administrator to determine if you qualify for continuation coverage.

Transfer Coverage

Each Blue Cross and Blue Shield (BCBS) plan is required to offer a transfer policy to members of other BCBS plans who are under age 65.

If you cease to be a member under this benefit plan (for any reason other than the Group changing insurance plans) and you move to an area served by another Blue Cross and/or Blue Shield plan, you may be eligible to enroll for transfer coverage with the BCBS plan serving your new address.

Transfer coverage available to you from the other BCBS plan may be very different from the coverage under this plan. If you do not wish to enroll in the transfer coverage, you may be eligible for other policies issued by other BCBS plans.

Individual Portability Coverage

You are eligible for certain individual coverage with no medical underwriting if you meet **all** of the following criteria:

- You have eighteen (18) months of prior continuous creditable coverage; the most recent coverage must be with a group, government or church plan, **and**
- You are no longer eligible for a group plan, Medicare or Medicaid, **and**
- Coverage was not terminated for nonpayment of premium or fraud, **and**
- You elected and exhausted COBRA continuation coverage (or other similar coverage) if this coverage was available to you, **and**
- You apply for individual portability coverage within sixty-three (63) days of the date your Group (or COBRA) coverage ends.

Please contact BCBSAZ for information on individual portability coverage.

Leave of Absence

If a Contractholder takes a leave of absence, the Group may continue coverage for the Contractholder and/or any Dependents for up to ninety (90) days, subject to payment of applicable premiums.

BCBSAZ will also continue coverage for members during any leave of absence the Group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 and any amendments or successor provisions. If the Contractholder returns to active employment by the end of the leave of absence period, coverage under this benefit plan will continue for the Contractholder and covered Dependents, so long as the Group maintains coverage with BCBSAZ. If not, the Contractholder will cease to be eligible and coverage for the Contractholder and Dependent(s) will terminate as described in *"Termination of Coverage."*

Medical Support Orders

Coverage is available to a child of the Contractholder in accordance with any court order or administrative order issued by a court of competent jurisdiction, that requires the Contractholder to provide health benefits coverage for such child.

The order must clearly specify the name of the Contractholder, the name and birth date of each child covered by the order and the time period to which the order applies.

Following receipt of the above information from the Group, BCBSAZ will add the child to the Contractholder's coverage, subject to BCBSAZ's guidelines for adding Dependent children, as outlined above. If the Contractholder does not have family coverage, the Contractholder is required to enroll for family coverage and pay any additional required premium.

Benefit-Specific Eligibility

Under the following limited circumstances, a nonmember may be eligible to receive benefits under this plan:

- If a transplant recipient is covered under this plan and the donor is not a member, the donor may be eligible for limited benefits (see benefit descriptions for Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures).
- If a non-member is pregnant with a baby that is to be adopted by a BCBSAZ member of this plan, the non-member may be eligible for maternity benefits under the following circumstances:

    - The child is adopted by a BCBSAZ member within one year of birth;
    - The member is legally obligated to pay the costs of birth; **and**
    - The member notified BCBSAZ that a court has certified the member as acceptable to adopt within 60 days of the court order or the effective date of this plan, whichever occurs later.

This benefit is considered secondary to any other coverage available to the birth mother.